12-2013

From Sex for Pleasure to Sex for Parenthood: How the Law Manufactures Mothers

Beth A. Burkstrand-Reid
University of Nebraska College of Law, bburkstrand-reid2@unl.edu

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As soon as sperm enter a woman, so do law and politics—or so the decades-long disputes surrounding abortion suggest. Now, however, renewed debates regarding contraceptives indicate that legal and political interference with women's sexual and reproductive autonomy may actually precede *the sperm. This Article argues that women even thinking about having sex are increasingly defined socially and legally as "mothers." Via this broad definition of who is a "mother," the State extends its reach into women's decisionmaking throughout their reproductive lifetimes.*

This Article argues that the State simultaneously devalues women's choices to have sex for pleasure, which this Article calls "desexualization," and uses medical rituals associated with motherhood, which this Article calls "ritualization," to persuade women to accept the role of mother. Desexualization and ritualization signal the State's attempt to influence women's sexual and reproductive decisionmaking not only in the context of abortion, but also in the areas of contraception, pregnancy, and childbirth.

* Assistant Professor, University of Nebraska College of Law; J.D., American University Washington College of Law; B.A., Emory University. Thank you to Jamie R. Abrams, Eric Berger, Eve M. Brank, Caroline Mala Corbin, Stephanie Davidson, Jason Eiker-Wiles, Jennifer S. Hendricks, Lisa C. Ikemoto, Craig M. Lawson, Jody Lyneé Madeira, Richard Moberly, Brian Reid, Sandra B. Zellmer, and Mary Ziegler for their comments on this project and to April I. Kirkendall, April L. Marty, Abby R. McConnaughhay, and Noëlle Anneliese Polk for their research assistance.

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Introduction

"'[B]eing against sex is not good. . . . Sex is popular.'"[1]

Sex is complicated. It can be physical, emotional, violent, tender, for pleasure or for procreation, and any combination of these.[2] Arguably, no other act can have so many different meanings and consequences, pregnancy included. But two things are certain: sex is popular, and women, specifically, are sexual beings.[3] Perhaps due to its near-universal appeal, sex is also a frequent subject of legal regulation.[4] Today, women are regulated—not as sexual beings but as would-be mothers—long before they ever have sex and certainly before they see a fetal image on an ultrasound screen, whether before an abortion or as a milestone on a path to childbirth.[5]

For women, "[s]ex for pleasure, for fun, or even for building relationships is completely absent from our national conversation."[6] Instead, the national focus is on "morality," a one-word descriptor for the anxiety that female

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1. Maureen Dowd, *Ghastly Outdated Party*, N.Y. Times, Feb. 25, 2012, http://www.nytimes.com/2012/02/26/opinion/sunday/dowd-ghastly-outdated-party.html (quoting Republican strategist Alex Castellanos). Sex may be procreative or not or to achieve intimacy or not. *See generally* Laura A. Rosenbury & Jennifer E. Rothman, *Sex In and Out of Intimacy*, 59 Emory L.J. 809 (2010). "Sex" in this Article refers to consensual, potentially procreative intercourse. *See* Krisztina Morvai, *What is Missing from the Rhetoric of Choice? A Feminist Analysis of the Abortion Dilemma in the Context of Sexuality*, 5 UCLA Women's L.J. 445, 460 (1995). "Pleasure," as used in this Article, is a positive "feeling, a sensation, a subjectively experienced phenomenon" stemming from sex. *See* Paul R. Abramson & Steven D. Pinkerton, With Pleasure: Thoughts on the Nature of Human Sexuality 45 (1995).

2. Sylvia A. Law, *Homosexuality and the Social Meaning of Gender*, 1988 Wis. L. Rev. 187, 225; *see* Margo Kaplan, *Sex-Positive Law*, 89 N.Y.U. L. Rev. (forthcoming Apr. 2014) (arguing that "sexual pleasure has value because of the pleasure it provides and apart from its ability to serve other ends such as emotional bonding or procreation"). Sex for pleasure and sex for procreation are not necessarily disaggregated, though in this Article the intent of sex for pleasure is pleasure itself, not procreation.

3. *See* Debby Herbenick et al., *Sexual Behavior in the United States: Results from a National Probability Sample of Men and Women Ages 14–94*, 7 J. Sexual Med. 255, 262 (2010) (detailing women's varied sexual activities). Anti-abortion-rights advocates may be portrayed as being "anti-sex." *See* Kristin Luker, Abortion and the Politics of Motherhood 210 (1984) (noting that people who are anti-abortion rights "value sex, of course, but they value it for its traditional benefits (babies)" rather than for intimacy).

4. Andrea Dworkin, Intercourse 185 (1987). For examples of social and legal regulation, see Elizabeth Bernstein & Laurie Schaffner, Regulating Sex: The Politics of Intimacy and Identity (2005); John D'Emilio & Estelle B. Freedman, Intimate Matters: A History of Sexuality in America (2012).

5. *See infra* Part III; *see also* Beth Burkstrand-Reid, *The War on Sex for Pleasure*, Huffington Post (May 16, 2012, 1:58 PM), http://www.huffingtonpost.com/beth-burkstrandreid/war-on-women_b_1521804.html (arguing that the "war on sex" targets both women and sex itself).

6. Jessica Valenti, The Purity Myth: How America's Obsession with Virginity is Hurting Young Women 43 (2009) [hereinafter Valenti, Purity Myth]. Strikingly, sex and sexuality are often not associated with motherhood. Beth Montemurro & Jenna Marie Siefken, *MILFS and Matrons: Images and Realities of Mothers' Sexuality*, 16 Sexuality & Culture 366, 367 (2012); Rebecca W. Tardy, *"But I* Am *a Good Mom": The Social Construction of Motherhood Through Health-Care Conversations*, 29 J. Contemp. Ethnography 433, 462–63 (2000). Women's sexuality is culturally constructed and influenced by male dominance. Catharine A. MacKinnon, Feminism Unmodified: Discourses on Life and Law 53 (1987).

sexuality provokes in the collective consciousness.[7] Increasingly, the State is the moral arbitrator of women's sexual choices.

While the dialogue on sexual activity has long focused on abortion,[8] more recent controversies have involved non-abortion reproductive health issues, such as contraception.[9] These debates boil down to one question about every woman: when she has sex, is she acting as a "slut," by having sex for pleasure, or as a "mother," by having sex for procreation?[10] The answer to this question has profound legal consequences for contraception policy, abortion rights, and even medical care during pregnancy.[11] This Article argues that for women today, there is no such thing as sex for pleasure under the law: only sex for the purpose of becoming a mother is considered legitimate, and women's sexual and reproductive health choices are regulated accordingly.[12]

So if you are a woman, are you a "slut" or a "mother"? Given that nearly all women use contraception during their lifetime, there are a lot of "sluts"—women having sex without intending to procreate—out there.[13] This Article argues that the law regulates women's reproductive choices by re-conceptualizing all sexually active (or potentially sexually active) women as

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7. Carol Groneman, Nymphomania: A History xvii (2000); Marty Klein, America's War on Sex: The Attack on Law, Lust and Liberty 2 (2006); Edward L. Rubin, *Sex, Politics, and Morality*, 47 Wm. & Mary L. Rev. 1, 2 (2005).

8. *State Policy Trends: Abortion and Contraception in the Crosshairs*, Guttmacher Inst. (Apr. 13, 2012), http://www.guttmacher.org/media/inthenews/2012/04/13/index.html ("In the first three months of 2012, legislators in 45 of the 46 legislatures that have convened this year introduced 944 provisions related to reproductive health and rights. Half of these provisions would restrict abortion access.").

9. Richard Wolf & Cathy Lynn Grossman, *Obama Mandate on Birth Control Coverage Stirs Controversy*, USA Today (Feb. 9, 2012), http://usatoday30.usatoday.com/news/washington/story/2012-02-08/catholics-contraceptive-mandate/53014864/1.

10. "Slut" is used in this Article because of its use in the Sandra Fluke controversy. *See* Julie Rovner, *Law Student Makes Case for Contraceptive Coverage*, Nat'l Pub. Radio (Feb. 23 2012, 4:39 PM), http://www.npr.org/blogs/health/2012/02/23/147299323/law-student-makes-case-for-contraceptive-coverage. "Slut" is defined by *Merriam-Webster Dictionary* as "a promiscuous woman; especially: PROSTITUTE." *Slut Definition*, Merriam-Webster.com, http://www.merriam-webster.com/ dictionary/slut (last visited Oct. 6, 2013); *see* Leora Tanenbaum, Slut!: Growing Up Female with a Bad Reputation 11 (1999) (arguing that "slut-bashing" is about more than sex—it reflects a girl's failure to behave according to social dictates). This Article adopts the *Oxford Dictionary*'s definition that motherhood occurs after birth. *Mother Definition*, OxfordDictionaries.com, http://oxforddictionaries.com/us/definition/american_english/mother (last visited Oct. 6, 2013) ("[A] woman in relation to a child or children to whom she has given birth."). This Article also acknowledges both the physical and social burdens of motherhood. Jennifer S. Hendricks, *Body and Soul: Equality, Pregnancy, and the Unitary Right to Abortion*, 45 Harv. C.R.-C.L. L. Rev. 329, 340–41 (2010).

11. *See infra* Parts II, III.

12. Robert D. Goldstein, Mother-Love and Abortion: A Legal Interpretation 13–16 (1988). This is not to say that puritanical notions of sexuality are new. *See generally* Gail Collins, America's Women: Four HundredYears of Dolls, Drudges, Helpmates, and Heroines (2003) (discussing the history of women, including women and sex).

13. Ninety-nine percent of women fifteen to forty-four years of age who have had intercourse have used contraception. William D. Mosher & Jo Jones, Ctrs. for Disease Control & Prevention, Use of Contraception in the United States: 1982–2008, at 5 (Aug. 2010).

mothers.[14] Motherhood is not just a biological status; it is a socially constructed role with built-in behavioral expectations—including some surrounding sexuality—that are imposed on women.[15]

In the context of abortion care, the State's use of the law to regulate women's reproductive choices is clear—focusing solely on abortion is a reductionist view of women, their health, and the State's role in women's lives.[16] By broadly defining "mother" to include all women of reproductive age, the State is able to extend its reach over women's reproductive lives and autonomous decisionmaking.[17] Moreover, when a woman is pregnant, the State can assert its authority to prohibit abortion or use its power to regulate the choices of the "mother" in order to protect the fetus.[18] These are but examples; the State regulates a woman's entire reproductive lifetime, not simply specific points within it. This blinds us to opportunities to improve women's health holistically and reduces women's autonomy.

This Article argues that the law effectively re-characterizes women as mothers by (1) desexualizing women, or advancing the notion that women should only have sex for procreation,[19] and (2) ritualizing women's healthcare by viewing and treating women (pregnant or not) as "pre-mothers," and using the law to impose medical and social practices associated with "good mothers" upon them.[20] The law embodies both desexualization and ritualization in many aspects of the regulation of women's sexuality. The presence of desexualization and ritualization in law and policy serves as a warning that the State is reaching into women's health-related decisionmaking. This Article further argues that desexualization and ritualization can be mobilized as legal

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14. Cynthia R. Daniels, At Women's Expense: State Power and the Politics of Fetal Rights 26 (1993) ("In this legal and political discourse, women's autonomy is traded against (and often traded away) by women's right to reproductive choice."). In the case of women who are already parenting, they are re-characterized as "mothers" of additional children-to-be, regardless of whether future pregnancy or parenting is desired. These women can still be "sluts" if they have sex for pleasure instead of sex for further procreation.

15. Rosalind Pollack Petchesky, *Beyond "A Woman's Right to Choose": Feminist Ideas About Reproductive Rights*, *in* The Reproductive Rights Reader: Law, Medicine, and the Construction of Motherhood 107 (Nancy Ehrenreich ed., 2008) ("[W]oman's reproductive situation is never the result of biology alone, but of biology mediated by social and cultural organization."); *see* Elisabeth Badinter, The Conflict: How Modern Motherhood Undermines the Status of Women 12–14 (2010); Jessica Valenti, Why Have Kids?: A New Mom Explores the Truth About Parenting and Happiness 4 (2012) [hereinafter Why Have Kids?]; Jessica Valenti, He's a Stud, She's A Slut And 49 Other Double Standards Every Woman Should Know 118–21 (2008); M. M. Slaughter, *The Legal Construction of "Mother"*, *in* Mothers in Law: Feminist Theory and the Legal Regulation of Motherhood 73 (Martha Albertson Fineman & Isabel Karpin eds., 1995). There are many types of mothers, mothering, and motherhood. *See* Carol Sanger, *M is for the Many Things*, 1 S. Cal. Rev. L. & Women's Stud. 15, 31–32 (1992).

16. Lynn M. Paltrow, *Abortion Issue Divides, Distracts Us from Common Threats and Threads*, A.B.A: Persps., Winter 2005.

17. *See infra* Part II.

18. *See infra* Parts II, III.

19. For many, this means having sex within marriage, even if that is not the case in practice. Richard A. Posner, Sex and Reason 243 (1992).

20. Kimberly M. Mutcherson, *Making Mommies: Law, Pre-Implantation Genetic Diagnosis, and the Complications of Pre-Motherhood*, 18 Colum. J. Gender & L. 313, 337 (2008).

tools used to transform women into "mothers," thus making their decisionmaking and their bodies fair game for regulation.

Part I of this Article examines the legal transformation of women into mothers by analyzing the conversion of "women's health" to "maternal health" in abortion jurisprudence. Subpart A briefly examines the conceptualization of health generally, women's health, and maternal health. It further details problems posed by the use of "maternal health" in the law as a descriptor for health issues faced by pregnant women. Subpart B argues that abortion jurisprudence is the exemplar for how the law co-opts women's health and thus transforms even non-pregnant women into mothers.

Part II argues that in both the abortion context and beyond, sexual and reproductive health laws desexualize women, re-characterizing women's desire to have sex for pleasure as an act of procreation instead, thus facilitating regulation of women's health far beyond abortion. Subpart A defines desexualization as advancing the notion that women should only have sex for procreation, and examines its development in the law. Subpart B argues that desexualization begins *before* sex, through stigmatization of sexually active women, as the debate around the Affordable Care Act ("ACA")—otherwise known as Obamacare—exemplifies. Subpart C uses the emergency contraception controversy to illustrate that once a woman has sex, she is assumed to have consented to the role of "mother," thus allowing the woman to be legally treated as a mother and her health treated as "maternal health."

Part III discusses the impact of ritualization in reproductive health law. Specifically, Part III focuses on how ritualization, in combination with desexualization, is mobilized in an attempt to control women's reproductive decisionmaking. Subpart A defines ritualization as the use of medical experiences related to pregnancy and childbirth to influence the sexual and reproductive decisionmaking of women. Abortion laws mimic the rituals of obstetrical care, for example, as a way of pushing women toward motherhood. Subpart B examines how this ritualization occurs outside of the abortion context, specifically during a continuing pregnancy, an area subject to extensive—but under-examined—legal regulation.

Finally, Part IV theorizes that future laws will employ ritualization and desexualization to reduce women's reproductive autonomy.[21] Subpart A discusses the current use of desexualization and ritualization in current controversies in contraception regulation and abortion legislation. Subpart B

21. *See generally* Lisa C. Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 Ohio St. L.J. 1205, 1207 (1992) [hereinafter Ikemoto, *Code of Perfect Pregnancy*] ("However, there is outstanding the idea and practice of controlling women with regard to conception, gestation, and childbirth in ways that express dominant cultural notions of motherhood."); Pamela Laufer-Ukeles, *Reproductive Choices and Informed Consent: Fetal Interests, Women's Identity, and Relational Autonomy*, 37 Am. J.L. & Med. 567, 568–69 (2011) (discussing how lawmakers and the public are "obsessed" with reproduction). This Article focuses on how potentially procreative sex is regulated. Procreative sex is but one form of sexual expression.

hypothesizes how future regulation of contraceptives may rest on desexualization and ritualization.

At its core, this Article theorizes that the law re-conceptualizes sexually active women, pushing them toward the role of a lifetime: motherhood.[22] After all, using contraceptives, for example, is "a license to do things in a sexual realm that is counter to how things are supposed to be."[23] When women resist the role of mother, they face marginalization and stigmatization—and, in some cases, legal control of their decisionmaking.

I. Women's Health Is Dead. Long Live Maternal Health

In 2006, the Centers for Disease Control and Prevention ("CDC") recommended that all women of childbearing age take vitamins, abstain from certain behaviors such as smoking and heavy drinking, and monitor their weight, all to prepare for eventual motherhood.[24] In essence, the government indicated that it viewed women as mothers-to-be.[25] Women are transformed into mothers via government actions that are ostensibly designed to protect women's health. We see this in regulatory contexts such as the CDC recommendations, as well as via various statutes and court decisions: the underlying questions are whose health is most important—the pregnant woman's or the fetus'—and who gets to make that determination.[26]

A. From Woman to Mother, Women's Health to Maternal Health

Abortion jurisprudence provides the quintessential example of the legal conceptualization of women as mothers.[27] We see this directly in Supreme Court rhetoric, which emphasizes "maternal" health despite the fact that not all sexually active women are mothers and not all women want to be mothers.[28]

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22. Turning women into "mothers" in the law via desexualization and ritualization may be intentional or an unintended result of broader social and legal policies.

23. Charles P. Pierce, *Santorum's War Against Women, Continued*, Esquire (Jan. 3, 2012, 3:41 PM), http://www.esquire.com/blogs/politics/rick-santorum-contraception-6632083 (quoting Rick Santorum); *see* John Bancroft, *Editorial: The Pill, Sex, and the Politics of Gender*, Medical Aspects of Human Sexuality (Mar. 2002) ("The idea that [the pill] might allow unmarried women to enjoy sex free of fears of pregnancy was anathema to many physicians, and concern that it might 'let loose' the sexuality of married women was not far below the surface.") (on file with Author).

24. Why Have Kids?, *supra* note 15, at 3–4.

25. *Id.*; *see* Rebecca Kukla, *Measuring Mothering*, 1 Int'l J. Feminist Approaches to Bioethics 67, 69 (2008); Jessica Valenti, Full Frontal Feminism 154–55 (2007).

26. Margo Kaplan, *"A Special Class of Persons": Pregnant Women's Right to Refuse Medical Treatment After* Gonzales v. Carhart, 13 U. Pa. J. Const. L. 145, 203 (2010).

27. Luker, *supra* note 3, at 193 ("[T]he abortion debate is so passionate and hard-fought *because it is a referendum on the place and meaning of motherhood*.").

28. Elizabeth A. Reilly, *The Rhetoric of Disrespect: Uncovering the Faulty Premises Infecting Reproductive Rights*, 5 Am. U. J. Gender & L. 147, 157–58 (1996) ("[T]he United States Supreme Court has consistently viewed women through their reproductive capacity. Women have been subsumed into their reproductive organs. The woman as an independent person with interests and needs is invisible in the Court's decisions: instead, law has treated women first and foremost as potential or actual mothers.").

To understand the differences between health, women's health, and maternal health, one may visualize a funnel. At the top of the funnel is the broadest category of "health," a non-sex-specific term referring to "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[29] Further into the narrowing funnel, we reach "women's health," which includes sex-specific health issues faced by women in their lifetime, including but not limited to concerns based on women's unique sexual and reproductive capacity.[30] Below women's health is an even smaller subset of women's health—some call it "maternal health"—which specifically relates to pregnancy, birth, and post-partum care.[31] Only some women experience these health issues. Almost one in five women end their reproductive years without having a child, double the percentage in the 1970s.[32]

When used in a legal context, the descriptor "maternal health" is often coupled with use of the term "mother" to refer to pregnant women.[33] When these terms are used together, the woman's health is no longer her own, but is tied up with the demands of motherhood even prior to childbirth. Thus, judicial use of the term "maternal health" when discussing pregnancy and childbirth is particularly problematic. Women's health is often reduced to maternal health, a transformation with significant implications.[34] Motherhood, after all, is not just a physical condition; it is also a social role.[35] In other words, legal protections of maternal health are not just a means to keeping women healthy; they propel women toward accepting a mothering role. This role requires a woman to

29. World Health Org. [WHO], *WHO Definition of Health*, http://www.who.int/about/definition/en/print.html (last visited Oct. 8, 2013). Within its general "health" definition, the WHO includes the non-sex-specific concept of "reproductive health," which concerns the functioning of "reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." WHO, *Health Topics: Reproductive Health*, http://www.who.int/topics/reproductive_health/en (last visited Oct. 8, 2013).

30. *See* U.S. Nat'l Library of Med., Nat'l Insts. of Health, *Women's Health*, http://www.nlm.nih.gov/medlineplus/womenshealth.html (last visited Oct. 8, 2013) ("Women have unique health issues. And some of the health issues that affect both men and women can affect women differently. Unique issues include pregnancy, menopause, and conditions of the female organs. Women can have a healthy pregnancy by getting early and regular prenatal care. They should also get recommended breast cancer, cervical cancer, and bone density screenings. Women and men also have many of the same health problems. But these problems can affect women differently.").

31. *See, e.g.*, WHO, *Health Topics: Maternal Health*, http://www.who.int/topics/maternal_health/en (last visited Oct. 8, 2013).

32. Gretchen Livingston & D'Vera Cohn, *Childlessness Up Among All Women; Down Among Women with Advanced Degrees*, Pew Research Ctr. (June 25, 2010), http://pewresearch.org/pubs/ 1642/more-women-without-children.

33. *See infra* Part I.B.

34. *See* Reilly, *supra* note 28, at 157–58, 164–65. Abortion jurisprudence frequently contains paternalistic concern for women's mental health, suggesting, for example, that women who have an abortion will regret their decision. Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 Duke J. Gender L. & Pol'y 223, 290 (2009).

35. Petchesky, *supra* note 15, at 107.

subrogate her needs—sexual and otherwise—to the needs of her fetus or child.[36] In reproductive health law, this means that the law focuses primarily on how the medical treatment of her body impacts her ability to fulfill her socially defined role as a mother.[37]

Abortion jurisprudence often conceptualizes all women as mothers or potential mothers. Such laws push women toward "maternal" roles, even when women are clearly rejecting motherhood, and ignore the importance of sex for pleasure.[38] Thus, abortion jurisprudence signals that to regulate women's reproductive autonomy, the law conceptualizes them as mothers. The law does so often by invoking "maternal health" even when a woman attempts to avoid motherhood. This signals desexualization, the notion that women should only have sex for procreation, and ritualization, viewing and treating women (pregnant or not) as "pre-mothers" and using the law to impose medical and social practices associated with "good mothers" upon them.[39]

B. Abortion and Motherhood Via Maternal Health

In *Roe v. Wade*, the germinal case confirming the right to have an abortion in some circumstances, the Supreme Court established a tripartite framework to judge the constitutionality of abortion restrictions.[40] In the standard itself, the Court vacillates between treating the pregnant woman as a woman or as a mother; its conceptualization of the woman seeking an abortion is dependent upon the point at which she seeks to end the pregnancy.[41] The woman remains a person separate from the fetus until the end of the first trimester: "For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the *pregnant woman's* attending physician."[42] The woman is still seen, at this point, as a person experiencing a medical condition—pregnancy—not a woman occupying the socially defined role of mother.[43]

However, at some point after the end of the first trimester, a "pregnant woman's" health becomes "maternal health" in the rhetoric of the decision, suggesting that the woman is then a mother: "For the stage subsequent to

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36. Badinter, *supra* note 15, at 12–14; Judith Warner, Perfect Madness: Motherhood in the Age of Anxiety 61–71 (2005); Mary Ziegler, *The Bonds That Tie: The Politics of Motherhood and the Future of Abortion Rights*, 21 Tex. J. Women & L. 47, 56–58 (2011).

37. *See, e.g.*, Gonzales v. Carhart, 550 U.S. 124, 159–60 (2007); Nancy Ehrenreich, *The Colonization of the Womb*, 43 Duke L.J. 492, 496–97 (1993).

38. *State Policy Trends 2013: Abortion Bans Move to the Fore*, Guttmacher Inst. (Apr. 11, 2013), http://www.guttmacher.org/media/inthenews/2013/04/11/index.html.

39. *See* Mutcherson, *supra* note 20, at 337; *infra* Parts II, III.

40. 410 U.S. 113, 164–65 (1973).

41. *Id. Roe* did not give women a positive right—the right existed naturally. Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 Yale L.J. 1394, 1403 (2009).

42. *Roe*, 410 U.S. at 164 (emphasis added).

43. *But see* Lisa C. Ikemoto, *Abortion, Contraception and the ACA: The Realignment of Women's Health*, 55 How. L.J. 731, 762–64 (2012) [hereinafter Ikemoto, *The Realignment of Women's Health*] (arguing that abortion has been disconnected from women's health).

approximately the end of the first trimester, the State, in promoting its interest in the health of the *mother*, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to *maternal health*."[44] That shift in language is illustrative.[45] From this point in the pregnancy, the State's interest is no longer conditioned solely on the pregnant woman's body, but also on her role as a mother.[46]

Many viewed *Roe* as empowering women because it ensured their ability to control their reproductive lives and to do so safely. But while *Roe* restricted the State's ability to limit women's access to abortion, it also empowered the State.[47] The decision specifically approved of abortion regulations during certain points in pregnancy if those regulations were premised on protecting "maternal health."[48] The Court uses the descriptor "mother" for women who clearly rejected that role at that time—they chose to have an abortion.[49] *Roe* signaled a deeper social and legal shift toward conceptualizing all sexually active women as mothers, a move that is now evident even outside of the abortion context.[50] As we will see, many of the most expansive actions of courts and legislatures today rely on *Roe* and its progeny, either for its health-related language, for its language on the State's interest in the fetus, or for the general assertion that the State may regulate women's bodies.

Some abortion cases subsequent to *Roe* chipped away at the right to access abortion.[51] *Planned Parenthood v. Casey*, for example, gave wide berth to government regulation of the procedure.[52] But issues related to the health of pregnant women and their rejection of their socially defined role as mothers

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44. *Roe*, 410 U.S at 164 (emphasis added). The Court's use of the "mother" descriptor continues through the "stage subsequent to viability" when it says the State "may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Roe*, 410 U.S. at 164–65.

45. Martha Minow, *Foreword: Justice Engendered*, 101 Harv. L. Rev. 10, 13–14 (1987); Julie Novkov, *A Deconstruction of (M)otherhood and a Reconstruction of Parenthood*, 19 N.Y.U. Rev. L. & Soc. Change 155, 159–60 (1992).

46. *See* Adrienne Rich, Of Woman Born: Motherhood as Experience and Institution 42 (1995); Ikemoto, *Code of Perfect Pregnancy*, *supra* note 21, at 1285 (stating that reproduction-related regulations "devalue women as persons by characterizing women as wombs").

47. *See generally* Cristina Page, How the Pro-Choice Movement Saved America: Freedom, Politics, and the War on Sex (2006) (discussing the continuing erosion of reproductive rights).

48. *Roe* vests the decision to have an abortion—and how to have that abortion—not with the woman, but largely with her doctor. 410 U.S. at 164–65.

49. *Id.* at 120.

50. *See, e.g.*, Jack M. Balkin, *How New Genetic Technologies Will Transform* Roe v. Wade, 56 Emory L.J. 843, 844 (2007); Reilly, *supra* note 28, at 159–160; *see also infra* Parts II, III.

51. For a discussion of the health impact of major abortion rulings, see generally Beth A. Burkstrand-Reid, *The Invisible Woman: Availability and Culpability in Reproductive Health Jurisprudence*, 81 U. Colo. L. Rev. 97 (2010) [hereinafter Burkstrand-Reid, *The Invisible Woman*]. For an overview of major abortion decisions, see David Masci & Ira C. Lupu, *A History of Key Abortion Rulings of the U.S. Supreme Court*, Pew Research Ctr.: Religion & Pub. Life Project (Jan. 16, 2013), http://www.pewforum.org/Abortion/A-History-of-Key-Abortion-Rulings-of-the-US-Supreme-Court.aspx.

52. Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 873–74 (1992). *Casey* also uses "mother" as a descriptor of pregnant women. *Id.* at 860.

came to a head in *Gonzales v. Carhart*, in which the Supreme Court upheld the federal partial-birth abortion ban even though it did not include an exception for the pregnant woman's health.[53]

Although the very word choice in the *Roe* decision—the shift from "pregnant woman" to "mother"—showed that pregnant women were considered would-be mothers after the first trimester of pregnancy, *Gonzales* further propelled the conceptualization of all pregnant women as mothers. *Gonzales* explicitly invoked notions of maternal guilt to shame pregnant women seeking an abortion and change their minds.[54] The majority opinion says:

> Respect for human life finds an ultimate expression in the bond of love the mother has for her child. . . . Whether to have an abortion requires a difficult and painful moral decision. While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow.[55]

The opinion continues:

> It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.[56]

These passages emphasize that the Court views women as mothers before childbirth, that the role of "mother" impacts legal rights, and that the Court believes that motherhood should impact the choices women make.

It cannot be overemphasized that the metaphysical transformation of pregnant women into mothers in abortion jurisprudence was done to women who were actively attempting to avoid the motherhood role at that time.[57] So it should come as no surprise that in non-abortion contexts, invocations of the social role of mother is used to limit women's reproductive and sexual autonomy.

When stripped to its core, sexual and reproductive health jurisprudence (abortion and beyond) is founded on what this Article labels desexualization

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53. Gonzales v. Carhart, 550 U.S. 124, 164–65 (2007).

54. *Id.* at 184–85 (Ginsburg, J., dissenting); B. Jessie Hill, *Dangerous Terrain: Mapping the Female Body in* Gonzales v. Carhart, 19 Colum. J. Gender & L. 649, 654–55 (2010).

55. *Carhart*, 550 U.S. at 159 (internal citations omitted). The abortion procedure at issue is called "partial-birth abortion," evoking the ultimate experience of motherhood: birth. *Id.* at 125.

56. *Id.* at 159–60.

57. *Casey*, 505 U.S. at 928 (Blackmun, J., concurring in part, concurring in the judgment in part, and dissenting in part) ("By restricting the right to terminate pregnancies, the State conscripts women's bodies into its service, forcing women to continue their pregnancies, suffer the pains of childbirth, and in most instances, provide years of maternal care. The State does not compensate women for their services; instead, it assumes that they owe this duty as a matter of course."); *see* Randi Hutter Epstein, Get Me Out: A History of Childbirth from the Garden of Eden to the Sperm Bank 114 (2010) (repeating the adage that women are made to bring children into the world); Balkin, *supra* note 50, at 851 ("[A]bortion laws treat women not as murderers, but as mothers, as people who exist to rear children.").

and ritualization, both of which reinforce the notion, so apparent in abortion jurisprudence, that all women are or will be mothers and should be regulated (and should themselves act) as such. "Desexualization" is the mechanism by which the State expresses its moral disapproval of any type of sexual activity other than sex for parenthood and, as a corollary, treats even the actions of sexually active women (or women considering sexual activity) as tantamount to accepting motherhood. "Ritualization" is the legally sanctioned use of the rituals or rites of passage associated with continuing pregnancies to push women toward accepting motherhood and behaving as "good mothers" even to the detriment of their health or rights. Part II discusses the first of these tools, desexualization, and how it contributes to the law's manufacturing of mothers.

II. Which Comes First: Sex or Motherhood? Law and Desexualizing Women

There is no doubt that many women enjoy sex, but are they supposed to?[58] Women are subjected to endless, sometimes conflicting, edicts about how and whether they should express their sexuality.[59] Desexualizing women through the law minimizes the importance, or even denies the existence, of women's desire for sex for pleasure and then re-characterizes women's sexual actions as implicit acceptance of motherhood.[60] It is the age-old division of women into Madonnas and whores.[61]

Although the right of women to access contraceptives was recognized decades ago, regulation of and access to contraceptives have again emerged as legal issues.[62] Two examples of this are the controversy surrounding contraceptive coverage in the ACA,[63] and the regulation of oral emergency contraceptives, also called the morning-after pill, or referred to by the brand names "Plan B" or "Plan B One-Step."[64] In both contexts, women are desexualized, their desire to have sex for pleasure is delegitimized, and sexual

58. Joann Ellison Rodgers, Sex: A Natural History 8 (2001); Herbenick et al., *supra* note 3, at 255; Daniel Kahneman et al., *A Survey Method for Characterizing Daily Life Experience: The Day Reconstruction Method*, 306 Science 1776, 1777 (2004). Women also partake in—and sometimes lead companies in—the nearly two billion dollar adult toy industry. Angus Loten, *Why Sex Sells More Than Ever*, Inc. (Jan. 25, 2008), http://www.inc.com/articles/2008/01/sex.html.

59. Montemurro & Siefken, *supra* note 6, at 385; Cas Wouters, *Sexualization: Have Sexualization Processes Changed Direction?*, 13 Sexualities 723, 724–26 (2010).

60. Rosenbury & Rothman, *supra* note 1, at 809. *But see* Martha Chamallas, *Consent, Equality, and the Legal Control of Sexual Conduct*, 61 S. Cal. L. Rev. 777, 838 (1988) ("A list of acceptable inducements [to sex] would surely include procreation, emotional intimacy, and physical pleasure. Of these three inducements, procreation probably plays a less significant social role today than either intimacy or pleasure.").

61. Stevi Jackson & Sue Scott, *Sexual Skirmishes and Feminist Factions: Twenty-Five Years of Debate on Women and Sexuality*, *in* Feminism and Sexuality: A Reader 3 (Stevi Jackson & Sue Scott eds., 1996).

62. *See infra* Parts II.B, C; *see also* Page, *supra* note 47, at 21 (asserting that some anti-abortion groups equate contraceptives and abortion).

63. Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 26 and 42 U.S.C.); *see infra* Part II.B.

64. *See infra* Part II.C.

activity is re-characterized as an affirmative step toward motherhood. And, once again, any act that casts a woman as a "mother" expands the State's ability to intervene in her choices.

A. Defining Desexualization

A core aspect of conceptualizing women as mothers in the law is viewing them—and treating them legally—as people who should engage in sexual activity for the purpose of parenthood, not pleasure: this is desexualization.[65] Desexualization consists of two actions: (1) shaming sex for pleasure and (2) reinforcing a norm that sex should be for the purpose of procreation or, for women more specifically, motherhood.

In society, motherhood and sexuality are in opposition.[66] A woman's success as a mother is defined in part by perceptions about her sexuality; some studies find that a less sexual mother is deemed to be a better mother.[67] The legal question, then, is when does a woman actually become a mother: upon a child's birth or sometime before?[68] Abortion jurisprudence demonstrates that the law labels a woman as a mother and her health "maternal" well before birth. But as the debates raging about contraceptives show, a woman may be conceptualized as a mother even before sex.[69]

The path to the desexualization of women in the law has been circuitous. For example, the Supreme Court has not been entirely prudish when it has confronted the issue of contraception, but that does not mean that it openly accepts sex for pleasure. Early on, members of the Court in *Poe v. Ullman* signaled that they recognized the importance of marital intimacy.[70] The Court

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65. Reilly, *supra* note 28, at 204 (describing "the assumptions that women are morally responsible only when fulfilling traditional expectations of the mother-role"). "Desexualization" is used in many ways. *See, e.g.*, Charles Winick, Desexualization in American Life 1–2 (1995) (recognizing that "changes were occurring in the social and sex roles, social structure, and popular culture" in the 1960s, when the book was written); Montemurro & Siefken, *supra* note 6, at 385 (using desexualization to refer to changes mothers experience post-partum); Wouters, *supra* note 59, at 726–28 (discussing desexualization in history, when sex was a duty and not for pleasure); s*ee also* Ellison v. Brady, 924 F.2d 872, 880 (9th Cir. 1991) (Title VII); Elizabeth F. Emens, *Intimate Discrimination: The State's Role in the Accidents of Sex and Love*, 122 Harv. L. Rev. 1307, 1401 (2009) (Disability); Anthony C. Infanti, *The Internal Revenue Code as Sodomy Statute*, 44 Santa Clara L. Rev. 763, 777 (2004) (Same-sex relationships); Morvareed Z. Salehpour, *Election 2008: Sexism Edition: The Problem of Sex Stereotyping*, 19 UCLA Women's L.J. 117, 134–35 (2012) (Politics).

66. Montemurro & Siefken, *supra* note 6, at 367. *See generally* Ariella Friedman et al., *Sexuality and Motherhood: Mutually Exclusive in Perception of Women*, 38 Sex Roles 781 (1998).

67. Montemurro & Siefken, *supra* note 6, at 385; Friedman et al., *supra* note 66, at 796–99.

68. Beth A. Burkstrand-Reid, *The More Things Change . . .: Abortion Politics & the Regulation of Assisted Reproductive Technology*, 79 UMKC L. Rev. 361, 370–72 (2010) [hereinafter Burkstrand-Reid, *The More Things Change*]; Jane C. Murphy, *Legal Images of Motherhood: Conflicting Definitions From Welfare "Reform," Family, and Criminal Law*, 83 Cornell L. Rev. 688, 689 (1998).

69. Page, *supra* note 47, at 30 ("[C]hildren are an intended purpose of intercourse, and parents should therefore act to responsibly care for and protect their pre-born children.").

70. Poe v. Ullman, 367 U.S. 497, 548 (1961) (Harlan, J., dissenting); *id.* at 519–20 (Douglas, J., dissenting); Brenda Cossman, Sexual Citizens: The Legal and Cultural Regulation of Sex and Belonging 23–24 (2007).

took a step toward recognizing the importance of sex for pleasure in *Griswold v. Connecticut*, which confirmed that married persons had the right to use contraceptives.[71] The *Griswold* Court said that "intimacy" had a role in the lives of married couples (and thus in the lives of married *women*) but, as the decision did not dwell on sex itself, the precedent focused on relationship building rather than pleasure.[72] By focusing on the marital relationship, *Griswold* also impliedly served a shaming function against sexually active people who were not married.[73]

Later, in *Eisenstadt v. Baird*, the Court jumped into law and sexuality with both feet by confirming that "whatever the rights of the individual to access to contraceptives may be, the rights must be the same for the unmarried and the married alike."[74] But again, the right did not focus on sex for pleasure. The Court's discomfort with sexuality lingered in tone, calling sex by the euphemism "the physical act."[75] Shaming was not overt, but the Court's discomfort with sexual activity was.[76]

The inevitable successor to the contraception cases—abortion jurisprudence—shows how the seed of the Court's discomfort with sexuality grew into desexualization and, eventually, would be expressed in legislation and jurisprudence.[77] *Roe* obscured the significance of physical intimacy by implicitly shaming sexually active women who were not married.[78] Women seeking an abortion were pushed toward accepting the role of mother.[79]

Roe's companion case, *Doe v. Bolton*, further cast women having sex outside of marriage as sexually suspect. In *Doe*, the Court went out of its way to establish that the "situation did not involve extramarital sex and its product,"

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71. Griswold v. Connecticut, 381 U.S. 479, 485–86 (1965).

72. *Id.* at 482 ("This law, however, operates directly on an intimate relation of husband and wife and their physician's role in one aspect of that relation."); *see* Law, *supra* note 2, at 226; *see also* Lawrence v. Texas, 539 U.S. 558, 565 (2003) ("After *Griswold*, it was established that the right to make certain decisions regarding sexual conduct extends beyond the marital relationship.").

73. *Griswold*, 381 U.S. at 498–99 (Goldberg, J., concurring) ("Finally, it should be said of the Court's holding today that it in no way interferes with a State's proper regulation of sexual promiscuity or misconduct.").

74. Eisenstadt v. Baird, 405 U.S. 438, 453 (1972); *see* Kendall Thomas, *Beyond the Privacy Principle*, 92 Colum. L. Rev. 1431, 1446 (1992).

75. *Eisenstadt*, 405 U.S. at 451 n.8.

76. The Court acknowledged, however, that sex for pleasure happened. *Id.* at 452–53 ("To say that contraceptives are immoral as such, and are to be forbidden to unmarried persons who will nevertheless persist in having intercourse, means that such persons must risk for themselves an unwanted pregnancy, for the child, illegitimacy, and for society, a possible obligation of support."); *see also Lawrence*, 539 U.S. at 578.

77. Abortion regulations "impair the possibility of sexual pleasure for women, and aggravate the force of sexual fear." Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 Stan. L. Rev. 261, 371 (1992).

78. Roe v. Wade, 410 U.S. 113, 120 (noting that Roe was not married); *id.* at 164 (stating the abortion decision "must be left to the medical judgment of the pregnant woman's attending physician").

79. *Id.* at 120, 164–65. *But see* Posner, *supra* note 19, at 333 (discussing the *Roe* decision as one supporting "morally indifferent sex"); *see* Courtney Megan Cahill, *Abortion and Disgust*, 48 Harv. C.R.-C.L. L. Rev. 409, 442 (2013) (discussing how abortion stigma relates to "shame associated with conduct that defines deeply rooted beliefs about women's social and biological roles").

implying that women who do *not* transgress that boundary are somehow more worthy of constitutional protection than those who do.[80] The Court's decision exemplifies how motherhood is treated as a "social institution," one that facilitates the control of women: in this case, their sexuality.[81]

Planned Parenthood v. Casey further retreated from *Eisenstadt*'s limited recognition of sex for pleasure. Although *Casey* recognizes that intimate decisionmaking relies to some degree on the availability of abortion, the decision, in part, grounded women's right to choose abortion in their ability to succeed as workers.[82] Sex and pregnancy were, at least in part, treated as economic issues and, at least impliedly, not issues of pleasure.[83] *Casey* abandoned *Roe*'s trimester framework in favor of the amorphous "undue burden" standard.[84] In *Casey*, the State interest in women's health begins to become a veil for a more politicized interest—the pre-viable fetus.[85] This interest in the pre-viable fetus further catapulted women toward motherhood.[86]

The government's ability to directly regulate sex was arguably curtailed by *Lawrence v. Texas*, in which the Supreme Court struck down a Texas sodomy statute, but *Lawrence* may have had as much—if not more—to do with preserving an individual's interest in building intimate relationships than in an individual's interest in sex in and of itself.[87] Even as it discussed *Casey*, *Lawrence* tied the right to engage in homosexual conduct to "persons in a homosexual *relationship*."[88] In *Gonzales*, however, the relationship at issue turned from one between adults to one between the pregnant woman and her fetus, directly implicating motherhood.

Gonzales linked women's sexuality to the rights of the fetus and thus propelled women toward motherhood.[89] *Gonzales* imbues the sexual act itself

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80. Doe v. Bolton, 410 U.S. 179, 196 (1973).

81. Friedman et al., *supra* note 66, at 783.

82. Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 856 ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.").

83. *Id.*

84. *Id.* at 878–79 (retaining *Roe*'s life and health exceptions, using both "woman" and "mother," and reaffirming *Roe*'s viability-related holding).

85. *Id.* at 872–73; Caitlin E. Borgmann, *Winter Count: Taking Stock of Abortion Rights After* Casey *and* Carhart, 31 Fordham Urb. L.J. 675, 681 (2004).

86. *Casey*, 505 U.S. at 878 ("To promote the State's profound interest in potential life, throughout pregnancy the State may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion. These measures must not be an undue burden on the right.").

87. Lawrence v. Texas, 539 U.S. 558, 567 (2003) ("The statutes do seek to control a personal relationship that, whether or not entitled to formal recognition in the law, is within the liberty of persons to choose without being punished as criminals. This, as a general rule, should counsel against attempts by the State, or a court, to define the meaning of the relationship or to set its boundaries absent injury to a person or abuse of an institution the law protects."); Kaplan, *supra* note 2 (arguing that *Lawrence* was less about sex and more about relationships).

88. *Lawrence*, 539 U.S. at 573–74 (emphasis added).

89. Gonzales v. Carhart, 550 U.S. 124, 159 (2007).

with the intent to parent: it warns women, addressing them as mothers, that they may regret ending "the infant life they once created and sustained" and cautioned that the woman's health may suffer from a decision to abort.[90] This so-called "fetal personhood" rhetoric implies that, once conceived, a fetus is a separate person with rights, thus, it has a mother.[91] Women are told that they "should become instantaneously 'motherly' from the moment of conception."[92] This contributes to what some call "maternal-fetal conflict," the purported clash of rights between a pregnant woman and the fetus.[93] Thus, women remain desexualized, purportedly destined to be mothers and expected to behave as such. If the State "couldn't stop growing numbers of women from climbing into the sexual driver's seat, they could at least make the women's drive more dangerous—by jamming the reproductive controls," and courts facilitate that move.[94]

B. Sluts or Mothers: "Pre-Pregnant" Women, Desexualization, and Obamacare[95]

Sex conjures notions of unbridled passion but also of unconstrained power, especially when it comes to women having sex for pleasure.[96] By using contraceptives, sexually active women gain some measure of legal autonomy by exhibiting power over their bodies and lives. However, there is a growing backlash against access to contraceptives, which reflects the view that "real women have babies": they do not have sex for pleasure, which requires contraceptives; they only have sex for procreation, which does not.[97] As these laws become more entrenched, women will continue to be desexualized through contraception policy, litigation, and regulation.

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90. *Id.* Researchers have questioned the Court's implication that women who have an abortion suffer from mental health problems as a result. *See* Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436, 445–49 (2008) (finding that high-quality research has suggested few if any negative mental health differences between women who have and have not had abortions).

91. Caitlin E. Borgmann, *The Meaning of "Life": Belief and Reason in the Abortion Debate*, 18 Colum J. Gender & L. 551, 562 (2009).

92. Rosalind Pollack Petchesky, Abortion And Woman's Choice: The State, Sexuality, and Reproductive Freedom 341 (rev. ed. 1990); *see* Hill, *supra* note 54, at 663–64.

93. Deborah Tuerkheimer, *Conceptualizing Violence Against Pregnant Women*, 81 Indiana L.J. 667, 688–95 (2006). For an extensive discussion of the regulation of pregnancy, see Ikemoto, *Code of Perfect Pregnancy*, *supra* note 21.

94. Susan Faludi, Backlash: The Undeclared War Against American Women 405 (1991).

95. *See* January W. Payne, *Forever*, Wash. Post (May 16, 2006), http://www.washingtonpost.com/ wp-dyn/content/article/2006/05/15/AR2006051500875.html (discussing the treatment of women as "pre-pregnant"); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 26 and 42 U.S.C.).

96. Cossman, *supra* note 70, at 24–25 (stating that "patrolling the borders" of when sex is and is not legitimate still took place after *Roe*); Klein, *supra* note 7, at 3; Friedman et al., *supra* note 66, at 783 ("As long as a woman's sexuality remains in the family sphere and is channeled to procreation, it receives full legitimacy. When her sexuality is 'uncontrolled' it is seen as illegitimate and is criticized and penalized.").

97. Valenti, *supra* note 25, at 151–52.

Ninety-nine percent of sexually active women use contraception at some point in their lives, making its use "virtually universal" in the United States.[98] More specifically, a survey of women conducted between 2006 and 2008 found that eighty-two percent of women have used oral contraceptives and ten percent have used emergency contraceptives—more than double the proportion of women who had used emergency contraceptives in 2002.[99] According to the Guttmacher Institute, the "typical American woman" who wants two children must use some mechanism of contraception for three decades.[100] The connection between contraception and women's health, broadly defined, is clear: contraceptives reduce maternal mortality and improve maternal-fetal outcomes by preventing unplanned pregnancies.[101] Contraceptives also have numerous other health benefits for women, including protection against certain cancers.[102]

The morality of contraception—or of sex for pleasure—resurfaced dramatically recently due to the ACA mandate requiring "women's preventive health care—such as mammograms, screenings for cervical cancer, prenatal care, and other services—generally must be covered by health plans with no cost sharing" including "[c]ontraceptive methods and counseling."[103] This mandate infuriated some employers and state governments, which alleged that the mandate violated religious freedom by forcing some employers not qualified for a religious exemption under the ACA to cover health services—such as contraceptives—that conflict with their faith.[104] Implicit in the

98. Mosher & Jones, *supra* note 13, at 5 (stating that nearly one hundred percent of sexually active women ages fifteen to forty-four surveyed from 2006 to 2008 who have ever had intercourse with a man have at some point in their lifetime used contraceptives, natural or artificial).

99. *Id.*

100. Rachel Benson Gold et al., Guttmacher Inst., Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System 6 (2009).

101. Marcia P. Harrigan & Suzanne M. Baldwin, *Conception, Pregnancy, and Childbirth*, *in* Dimensions of Human Behavior: The Changing Life Course 53, 56–57 (Elizabeth D. Hutchinson ed., 2d ed. 2003); *see* Kenneth R. Weiss, *Contraception Key to Reducing Child, Maternal Deaths, Experts Say*, L.A. Times (July 12, 2013), http://www.latimes.com/news/science/sciencenow/la-sci-sn-contraception-key-to-reducing-child-maternal-deaths-experts-say-20130712,0,1549550.story.

102. Boston Women's Health Book Collective, Our Bodies, Ourselves 225 (2011) [hereinafter Our Bodies, Ourselves].

103. *See* Health Resources & Servs. Admin., U.S. Dep't of Health & Human Servs., *Women's Preventive Services Guidelines*, http://www.hrsa.gov/womensguidelines (last visited Oct. 6, 2013); *see also* Remarks by the President on Preventive Care (Feb. 10, 2012), *available at* http://www.whitehouse.gov/ the-press-office/2012/02/10/remarks-president-preventive-care. For a collection of news articles on healthcare reform, see also *Health Care Reform*, N.Y. Times (Times Topics), http://topics.nytimes.com/top/ news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/ health_care_reform/index.html (last visited Oct. 6, 2013).

104. Caroline Mala Corbin, *The Contraception Mandate*, 107 N.W. U.L. Rev. Colloquy 151, 151 (2012); *7 States Sue Over Obama Administration's Birth Control Rule*, USA Today (Feb. 23, 2012), http://usatoday30.usatoday.com/news/washington/story/2012-02-23/states-sue-obama-birth-control/53228212/1; Warren Richey, *Obama Administration Backs Out of Appeal Over New Contraceptive Mandate*, Christian Sci. Monitor (May 6, 2013, 8:58 PM), http://www.csmonitor.com/ USA/Justice/2013/0506/Obama-administration-backs-out-of-appeal-over-new-contraceptive-mandate-video;

objections is the notion that sex for pleasure should not be subsidized, suggesting that sex for procreation is the only appropriate type of sex.[105] President Obama later offered compromises concerning the contraception mandate, attempting to assuage employers' concerns, though those compromises did little to avert litigation over the validity of the ACA.[106]

On one hand, the ACA contraception mandate can be seen as the quintessential government recognition that women do have sex for pleasure—and *should* be able to have sex for pleasure—without suffering from undesired consequences. The pushback on the ACA by other government actors, employers, media pundits, states, and individual lawmakers, however, emphasizes the vast the disapproval of women's non-procreative sexuality.[107] One prime example: Sandra Fluke.

Fluke, then a law student at Georgetown University, was scheduled to testify before Congress on the importance of contraceptive coverage but was refused by the United States House Committee on Oversight and Government Reform.[108] She later testified before a panel of House Democrats.[109] Her testimony was followed by comments from media personality Rush Limbaugh:

> What does it say about the college coed Susan Fluke [sic], who goes before a congressional committee and essentially says that she must be paid to have sex? What does that make her? It makes her a slut, right? It makes her a prostitute. She wants to be paid to have sex. She's having so much sex she can't afford the contraception. She wants you and me and the taxpayers to pay her to have sex. What does that make us? We're the pimps.[110]

By lobbying for contraceptive coverage, Fluke was "happily presenting herself as an immoral, baseless, no-purpose-to-her life woman;" attending an elite law school and becoming a lawyer was not a legitimate life purpose for a

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HHS Mandate Information Central, Becket Fund for Religious Liberty, http://www.becketfund.org/hhsinformationcentral/ (last visited Sept. 8, 2013) (identifying 67 cases and more than 200 plaintiffs). The type of contraceptive objected to varies. *FAQs: Becket Fund's Lawsuits Against HHS*, Becket Fund For Religious Liberty, http://www.becketfund.org/faq/#f5 (last visited Oct. 23 2013) ("Although many of these institutions do not have objections to traditional contraception, all are opposed to abortion-inducing drugs, such as the 'morning after pill' and 'week after pill.'")

105. Certainly, some women who use contraceptives are already mothers in that they have given birth to children. The analysis applies to these women, too, as they may be attempting to prevent additional pregnancies.

106. Morgan Whitaker, *Obama Tweaks Birth Control Mandate to Accommodate Religious Groups*, MSNBC.com (Feb. 1, 2013, 1:15 PM), http://tv.msnbc.com/2013/02/01/obama-clarifies-contraception-mandate-to-accomodate-religious-groups; *see* 45 C.F.R. § 147.130-131 (2013) (outlining the requirements for a "religious employer").

107. *See infra* notes 114–116.

108. Alexa Keyes, *Contraception Controversy Continues: Meet Witness Sandra Fluke*, ABC News (Feb. 23, 2012, 2:34 PM) http://abcnews.go.com/blogs/politics/2012/02/contraception-controversy-continues-meet-witness-sandra-fluke.

109. *Id.*

110. Media Matters Staff, *Limbaugh: Student Denied Spot at Contraception Hearing Says "She Must Be Paid to Have Sex," So She's A "Slut" and "Prostitute"*, Media Matters for Am. (Feb. 29, 2012, 2:46 PM), http://mediamatters.org/video/2012/02/29/limbaugh-student-denied-spot-at-contraception-h/186411 (providing a recording and transcript of Rush Limbaugh's comments about Sandra Fluke).

woman, and, if there was any legitimacy in that endeavor, the potential of any woman to have non-procreative sex overshadowed her accomplishments.[111] Fluke was forced into the role of mother-in-waiting because she was assumed to be sexually active. And, the only legitimate "purpose to her life," if she had sex, would be to procreate.

Limbaugh may have been the most famous talking head to address the contraception mandate, and his comments were histrionic at best, but he is far from the only prominent person to publically decry the law. Company after company, school after school, state after state, and lawmaker after lawmaker fought contraceptive coverage, even directly challenging the value of sex for pleasure.[112] Former presidential candidate Rick Santorum, the state of Nebraska, Hobby Lobby, and Domino's Pizza are just a few.[113]

Regardless of whether the asserted sexual authority of the religious right trumps the autonomy of women as the ACA winds its way through the courts, any failure to cover contraceptives—and, therefore, recognize sexuality—contributes to women's desexualization in society. These attacks thus buttress entrenchment of desexualization by the State by eliminating resources that would allow women the ability to avoid or delay motherhood. This is the essence of desexualization.

The ACA controversy demonstrates that desexualization and its relationship with law and public policy begins long before pregnancy.[114] But the contraception mandate controversy is merely a gateway to how law and policy express desexualization. Desexualization intensifies as a tool for transforming women into mothers when women have already had sex and are dealing with a potential consequence: pregnancy.

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111. Media Matters Staff, *UPDATED: Limbaugh's Misogynistic Attack On Georgetown Law Student Continues With Increased Vitriol*, Media Matters for Am. (Mar. 1, 2012, 3:26 PM), http://mediamatters.org/blog/2012/03/01/updated-limbaughs-misogynistic-attack-on-george/184248 (providing summary and recording of Rush Limbaugh's comments).

112. Becket Fund for Religious Liberty, *supra* note 104 (detailing lawsuits filed over the ACA mandate); Irin Carmon, *Rick Santorum is Coming for Your Birth Control*, Salon (Jan. 4, 2012, 6:30 PM), http://www.salon.com/2012/01/04/rick_santorum_is_coming_for_your_birth_control.

113. *See, e.g.*, Monaghan v. Sebelius, No. 12-15488, 2013 WL 1014026, at *1 (E.D. Mich. Mar. 14, 2013); Bruning v. Dep't of Health & Human Servs., 877 F. Supp. 2d 777, 779 (D. Neb. 2012); Hobby Lobby Stores, Inc. v. Sebelius, No. 12-1000, 2013 WL 3869832, at *1 (W.D. Okla. July 19, 2013); Terry Baynes, *U.S. Court Accepts Challenge to Obama Contraception Rule*, Reuters (June 28, 2013, 2:07 AM), http://in.reuters.com/article/2013/06/27/us-hobby-lobby-contraception-idINBRE95Q15N20130627; *see also*, Carmon, *supra* note 112.

114. Preventative care is sometimes referred to as "[p]reconception and interconception care," which are "health care services and supports that are provided prior to a pregnancy . . . designed to assure that women are healthy before conception in order to improve pregnancy-related outcomes." Carolyn Mullen, *The Affordable Care Act and Preconception Health*, Pulse 9–10, Nov. 2011, *available at* http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Documents/Pulse_November11.pdf.

C. Motherhood the Morning After

Women trying to avoid pregnancy can use pre-intercourse contraceptives, some without a prescription and some, including oral contraceptives, with a prescription.[115] There are also oral, post-coital contraceptives, sometimes called emergency contraception, the morning-after pill, or the brand names "Plan B" or "Plan B One-Step."[116] Recently, some emergency contraceptives were made available without a prescription, but availability was restricted on the basis of age.[117] Efforts to make some emergency contraceptives available without a prescription and without age restrictions carried on for years and only recently achieved some success.[118]

Emergency contraception does not implicate motherhood or maternal health: there is no "mother" involved.[119] The concept of "maternal" health generally, and abortion more specifically, should have no bearing on the regulation of emergency contraceptives, which prevent—not end—pregnancy.[120] Yet as the controversies surrounding the availability of emergency contraceptives show, engaging in intercourse may signal that a woman has accepted the role of mother, even as she tries to prevent motherhood.

Similar to pre-coital contraceptives,[121] emergency contraceptives prevent pregnancy by stopping ovulation.[122] Emergency contraceptives must be taken

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115. Planned Parenthood, *Birth Control Pills*, http://www.plannedparenthood.org/health-topics/birth-control/birth-control-pill-4228.htm (last visited Oct. 6, 2013) (reporting that pills cost as much as $50 per month and a medical exam prior to getting them, at a cost of up to $250, may be necessary).

116. There are numerous types of emergency contraceptives. *See Types of Emergency Contraception*, The Emergency Contraception Website, http://ec.princeton.edu/questions/brands-usa.html (last visited Oct. 6, 2013) (providing information from the Office of Population Research at Princeton University and the Association of Reproductive Health Professionals on various types of oral emergency contraceptives); *Copper-T IUD as Emergency Contraception*, The Emergency Contraception Website, http://ec.princeton.edu/info/eciud.html (last visited Oct. 6, 2013) (describing the use of an IUD as emergency contraception). Emergency contraception or contraceptives in this Article refers to oral emergency contraception or contraceptives. *See Emergency Contraception State Laws*, Nat'l Conference of State Legislators, http://www.ncsl.org/issues-research/health/ emergency-contraception-state-laws.aspx (last updated Aug. 2012) (discussing state emergency contraception regulations, including dispensing by pharmacists).

117. *See* News Release, Food & Drug Admin., FDA Approves Plan B One-Step Emergency Contraceptive for Use Without a Prescription for All Women of Child-Bearing Potential (June 20, 2013), *available at* http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm358082.htm [hereinafter *FDA Approves Plan B One-Step Without Prescription*] (saying Plan B One-Step was approved in 2009 for use by women age seventeen and over; the age was lowered to fifteen in April 2013).

118. *Id.* (approving Plan B One-Step for all women on a non-prescription basis); Tummino v. Hamburg, Memorandum, No. 12-0763, 2013 WL 2631163, at *1 (E.D.N.Y. June 12, 2013) (discussing levonorgestrel-based contraceptives).

119. *See Mother Definition*, *supra* note 10.

120. *How Emergency Contraception Works*, The Emergency Contraception Website, http://ec.princeton.edu/questions/ecabt.html (last visited Oct. 6, 2013).

121. *FDA Approves Plan B One-Step Without Prescription*, *supra* note 117 ("The product contains higher levels of a hormone found in some types of daily use oral hormonal contraceptive pills and works in a similar way to these contraceptive pills by stopping ovulation and therefore preventing pregnancy."). For general

quickly after intercourse in order to maximize efficacy.[123] Although some anti-reproductive-rights advocates argue that emergency contraceptives may prevent a fertilized egg from implanting in the uterus, scientists say there is no evidence that emergency contraceptives function in that capacity.[124] In other words, studies—and the Food and Drug Administration ("FDA")—contend that emergency contraceptives do not end an established pregnancy.[125] Still, some argue that emergency contraceptives are abortifacients. For example, the American Right to Life organization says that "the greatest danger of the 'Morning After Pill' is that it is designed to kill a child."[126]

In addition to the initial, prescription-only status of emergency contraceptives, access to the medications has been restricted in other ways. The federal government, until recently, restricted availability based on age.[127] Additionally, pharmacists—and perhaps even others—may be allowed to refuse to dispense emergency contraceptives.

The sexuality of *young* women is perhaps the most feared sexuality of all as, in most cases, it is overtly sex for pleasure.[128] It can also have massive, unintended ramifications in terms of unplanned pregnancy.[129]

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information on oral contraceptives, see *FAQ: Birth Control Pills*, Am. Coll. of Obstetricians & Gynecologists (Mar. 2013), http://www.acog.org/~/media /For%20Patients/ faq021.pdf?dmc=1&ts=20130619T2102509049.

122. Pam Belluck, *Abortion Qualms on Morning-After Pill May Be Unfounded*, N.Y. Times (June 5, 2012), http://www.nytimes.com/2012/06/06/health/research/morning-after-pills-dont-block-implantation-science-suggests.html?pagewanted=all&_r=0 (asserting that the debate over how emergency contraceptives work has been largely resolved and that it is not an abortifacient, but discussing contrary views).

123. *FAQ: Emergency Contraception*, Am. Coll. of Obstetricians & Gynecologists(Aug. 2011), http://www.acog.org/~/media/For%20Patients/faq114.pdf?dmc=1&ts=20130619T2106435514.

124. *Id.*; Belluck, *supra* note 122.

125. *See FDA Approves Plan B One-Step Without Prescription*, *supra* note 117 ("Plan B One-Step will not stop a pregnancy when a woman is already pregnant and there is no medical evidence that the product will harm a developing fetus."); Belluck, *supra* note 122 *(*citing Mayo Clinic physicians, National Institutes of Health, and International Federation of Gynecology and Obstetrics officials as saying emergency contraception does not work post-fertilization).

126. *Plan B Side Effect On Younger and Younger Girls*, Am. Right to Life, http://americanrtl.org/news/plan-b-side-effect-daughters (last visited Oct. 6, 2013); *see* Elizabeth Shadigian, *Letter to the FDA Regarding Over-The-Counter Status For Plan B*, Am. Ass'n of Pro-Life Obstetricians & Gynecologists, http://www.aaplog.org/position-and-papers/emergency-contraception/letter-to-the-fda-regarding-over-the-counter-status-for-plan-b (last visited Oct. 6, 2013) ("Plan B's labeling does not give adequate notice to a potential user that Plan B may prevent the implantation of a human embryo (e.g., a fertilized ovum) as one mechanism of action, thus acting as an abortifacient."); *Plan B [Emergency Abortion Pill] FAQs*, Pharmacists for Life Int'l, http://www.pfli.org/main.php?pfli=planbfaq (last visited Oct. 6, 2013).

127. *See Plan B: Questions and Answers*, Food & Drug Admin., http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm109783.htm (last updated Dec. 14, 2006) (announcing Plan B approval over-the-counter for women eighteen years and older).

128. *See generally* Sinikka Elliott, Not My Kid: What Parents Believe About the Sex Lives of Their Teenagers (2012) (discussing the disconnect between actual sexual activity and parental perceptions of it); Amy T. Schalet, Not Under My Roof: Parents, Teens, and the Culture of Sex (2011) (comparing U.S. attitudes toward teen sex with other countries); Deborah L. Tolman, Dilemmas of Desire: Teenage Girls Talk about Sexuality (2002) (discussing fear over girls' sexuality); Valenti, Purity Myth, *supra* note 6 (discussing the harm girls face from lacking a comprehensive understanding of sexuality); *In Brief: Fact Sheet, Facts on American Teens' Sexual and Reproductive Health*, Guttmacher Inst. (June 2013), http://www.guttmacher.org/pubs/FB-ATSRH.html (reporting that fewer than two percent of adolescents

In 2011, Department of Health and Human Services Secretary Kathleen Sebelius refused to follow the guidance of FDA staff, who recommended that Plan B One-Step be made more widely available to young women without a prescription.[130] She rejected the recommendations of her own agency and said that there was insufficient proof that young women could understand how to use the drug or the consequences of its use.[131] Ultimately, her actions were called "obviously political" by a federal district court judge, who ordered the FDA to "make levonorgestrel-based emergency contraceptives available without a prescription and without point-of-sale or age restrictions."[132] Eventually, after the Second Circuit denied in part the government's request for a stay pending appeal, the Obama administration capitulated: Plan B One-Step was made available without a prescription or point-of-sale restrictions regardless of a woman's age (assuming that a woman can afford it and is not otherwise obstructed from accessing it).[133] Obstructions, however, are likely;

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younger than twelve are sexually active, sixteen percent by age fifteen, one-third by age sixteen, and that 750,000 teens between fifteen and nineteen years old get pregnant each year). A minor's right to access contraceptives has long been controversial, as is seen in the fragmented decision in *Carey v. Population Control Servs. Int'l*, 431 U.S. 678 (1977), and discussed in Angela Patterson, Carey v. Population Services International*: Minors' Right to Access Contraceptives*, 14 J. Contemp. Legal Issues 469 (2004); s*ee also State Policies in Brief, Minors' Access to Contraceptive Services*, Guttmacher Inst. (Aug. 1, 2013), http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf.

129. *Teen Pregnancy Prevention*, Nat'l Conference of State Legislatures, http://www.ncsl.org/issues-research/health/teen-pregnancy-prevention.aspx (last visited Oct. 6, 2013) ("Teenage mothers are less likely to finish high school and are more likely than their peers to live in poverty, depend on public assistance, and be in poor health. Their children are more likely to suffer health and cognitive disadvantages, come in contact with the child welfare and correctional systems, live in poverty, drop out of high school and become teen parents themselves. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, the annual public cost of teen childbearing—due to higher costs of public health care, foster care, incarceration and lost tax revenue—is nearly $11 billion.").

130. News Release, Dep't of Health & Human Servs., A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius (Dec. 7, 2011), *available at* http://www.hhs.gov/news/press/2011pres/12/20111207a.html [hereinafter Sebelius Statement] (using the terms "Plan B One-Step", "emergency contraceptive," and "morning after pill" in the release).

131. News Release, Food & Drug Admin., Statement from FDA Commissioner Margaret Hamburg, M.D., on Plan B One-Step (Dec. 7, 2011), *available at* http://www.fda.gov/NewsEvents/ Newsroom/ucm282805.htm [hereinafter Hamburg Statement]; Sebelius Statement, *supra* note 130; Sam Baker, *Left 'Speechless' as Sebelius Overrules FDA on Access to Morning-After Pill*, The Hill (Dec. 7, 2011), http://thehill.com/blogs/healthwatch/abortion/197825-sebelius-overrules-fda-blocks-access-to-plan-b (discussing the notion that the secretary "bow[ed] to political pressure" and ignored her own agency's scientists); *HHS Overrules FDA, Limiting Plan B for Teens Under 17*, USA Today (Dec. 8, 2011), http://www.usatoday.com/news/health/healthcare/health/healthcare/story/2011-12-07/FDA-debates-over-the-counter-morning-after-pill/51699388/1.

132. Tummino v. Hamburg, No. 12-0763, 2013 WL 1348656, at *7, *31 (E.D.N.Y. Apr. 5, 2013). This was not the first time the district court noted political interference in emergency contraception regulation. Tummino v. Torti, 603 F. Supp. 2d 519, 547–50 (E.D.N.Y. 2009) (ordering the FDA to make Plan B available to women age 17 without a prescription).

133. Tummino v. Hamburg, No. 13-1690, 2013 WL 2435370, at *1 (2d Cir. June 5, 2013) ("Insofar as the district court order requires Appellants to immediately provide over-the-counter access to the one-pill variants of emergency contraceptives, a stay, pending appeal, is granted. Insofar as the order mandates immediate over-the-counter access to the two-pill variants of emergency contraceptives, a stay is denied because the

despite the non-prescription status and lack of age restrictions for Plan B One-Step, pharmacists have already said they may continue to keep it behind the counter and limit access by age.[134]

From a policy perspective, the regulation of emergency contraception for minors exposes a paradox. If we break down desexualization, we see that it involves two steps: (1) a shaming of sex for pleasure, and (2) a push toward motherhood. The first move of desexualization may seem appropriate when it comes to young women.[135] However, taking the second step and pushing young women toward motherhood is counterintuitive. Once unprotected sex has occurred, opponents of non-prescription emergency contraceptives for younger women appear to fear the possibility of promiscuity among young women more than they fear teen pregnancy, even though studies show the availability of emergency contraceptives does not increase sexual activity.[136] This is remarkable; once they have sex, young women were—and arguably still are—pushed toward motherhood seemingly as a punishment either for failure to use contraceptives or for being sexually active at all.[137] This is desexualization. Whether young or not, women are not to have sex for pleasure and, if they do, they are deemed to have accepted the role of mother, no matter their age.

Government actions to limit the availability of emergency contraceptives propel women toward motherhood and do so without providing health information related to pregnancy. Sebelius, for example, said that young girls might not understand the Plan B One-Step label, justifying limitations on its availability.[138] Her actions suggested that young women could not make good

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Appellants have failed to meet the requisite standard."). *FDA Approves Plan B One-Step Without a Prescription*, *supra* note 117; Letter from U.S. Attorney, E.D.N.Y. Loretta E. Lynch to Hon. Edward R. Korman (June 10, 2013), *available at* http://media.npr.org/documents/ 2013/jun/justiceletter.pdf (asserting that the government had complied with the Court's prior judgment and that the FDA "will not at this time take steps" to change the status of other emergency contraceptives). For information regarding the regulatory status of other contraceptives, see *Where Should EC Be? FDA-Approved Emergency Contraceptive Products as of August 1, 2013*, Reprod. Health Techs. Project, http://www.rhtp.org/contraception/emergency/documents/WhereShouldECBe.August12013.pdf.

134. Meeri Kim, *Questions About Effect of Over-The-Counter Plan B for All Ages*, Wash. Post (June 29, 2013), http://articles.washingtonpost.com/2013-06-29/national/40268209_1_emergency-contraception-plan-b-one-step-age-restrictions.

135. *But see* Valenti, Purity Myth, *supra* note 6, at 9–10 (arguing that the focus on virginity discourages girls from safe expressions of sexuality).

136. Klein, *supra* note 7, at 38; *see* Carey v. Population Control Servs. Int'l, 431 U.S. 678, 694–95 (1977) (quoting Eisenstadt v. Baird, 405 U.S. 438, 448 (1972)). *But see Editorial: Docs Push Plan B: Putting Girls' Health at Risk to Prevent Pregnancy*, Wash. Times (Nov. 29, 2012), http://www.washingtontimes.com/news/2012/nov/29/docs-push-plan-b.

137. *See supra* note 136. *See generally* Valenti, Purity Myth, *supra* note 6 (discussing how girls are taught to fear their sexuality).

138. *Compare* Hamburg Statement, *supra* note 131 ("[Plan B One-Step] was safe and effective in adolescent females, that adolescent females understood the product was not for routine use, and that the product would not protect them against sexually transmitted diseases. Additionally, the data supported a finding that adolescent females could use Plan B One-Step properly without the intervention of a healthcare provider."), *with* Sebelius Statement, *supra* note 130 ("the actual use study and the label comprehension study

health decisions related to contraception, but at the same time, young women's ability to make good health decisions related to pregnancy—which carries with it health risks, too—were not discussed in her statement, thus undermining any argument that the Plan B One-Step restriction was intended as a health protection.[139] Her invocation of girls' health to deny access to emergency contraceptives was particularly disingenuous given that the drug was still available to girls by prescription.[140] According to prominent physicians, "[a]ny objective review makes it clear that Plan B is more dangerous to politicians than to adolescent girls."[141] We will see this misleading use of women's health against women's autonomy again in the context of abortion and cesarean sections.[142]

Moreover, some states have enacted laws that allow some healthcare providers to deny women access to reproductive health services.[143] These laws were first passed in response to *Roe* and allow medical providers, among other actions, to refuse to dispense drugs that may conflict with their moral or religious beliefs.[144] Changes in the way that emergency contraceptives are dispensed may lessen the potential impact of pharmacist refusal. However, opportunities for pharmacists and other employees of retailers that sell Plan B One-Step to obstruct access will undoubtedly still exist.[145]

Refusing to dispense emergency contraceptives is tantamount to declaring a sexually active woman to be "pregnant," and thus a mother, the instant she has sex.[146] Women are explicitly desexualized through these clauses. When healthcare providers refuse to dispense emergency contraceptives, they push women toward motherhood, often with State support.[147]

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are not sufficient to support making Plan B One-Step available to all girls 16 and younger, without talking to a health care professional."); Ikemoto, *The Realignment of Women's Health*, *supra* note 43, at 766.

139. *See generally* Heidi Murkoff & Sharon Mazel, What to Expect When You're Expecting (2008) (discussing various health risks women face when pregnant).

140. Tummino v. Hamburg, No. 12-0763, 2013 WL 1348656, at *4 (E.D.N.Y. Apr. 5, 2013).

141. Alastair J.J. Wood et al., *The Politics of Emergency Contraception*, 366 New Eng. J. Med. 101, 102 (2012).

142. *See infra* Part III.

143. State "conscience clause" laws allow medical providers to deny healthcare services based on their individual beliefs. *Pharmacist Conscience Clauses Laws and Information*, Nat'l Conference of State Legislatures, http://www.ncsl.org/issues-research/health/pharmacist-conscience-clauses-laws-and-information.aspx (last updated May 2012); *State Policies in Brief, Refusing to Provide Health Services*, Guttmacher Inst. (Aug. 1, 2013), http://www.guttmacher.org/statecenter/spibs/ spib_RPHS.pdf.

144. *Id.; see* Burkstrand-Reid, *The Invisible Woman*, *supra* note 51, at 114–22.

145. Kim, *supra* note 134.

146. *Id. See Pharmacy Refusals 101*, Nat'l Women's Law Ctr. (Apr. 24, 2012), http://www.nwlc.org/resource/pharmacy-refusals-101 ("In Milwaukee, Wisconsin, a mother of six went to her local Walgreens with a prescription for emergency contraception. The pharmacist refused to fill the prescription and berated the mother in the pharmacy's crowded waiting area, shouting 'You're a murderer! I will not help you kill this baby . . . .' She subsequently became pregnant and had an abortion.").

147. Some people even feel so strongly that all sex is procreative that they think women who are sexually assaulted should welcome the role of motherhood even if it is—literally—forced up on them. John Avlon, *GOP Policy is the Scandal, Not Just Akin's Comments*, CNN (Aug. 21, 2012), http://www.cnn.com/2012/08/21/opinion/avlon-akin-gop/index.html; Mark Memmott, *"God Intended" A*

Whether expressed by a private employer or by a government official, desexualization is identifiable in the law. When it came to the ACA, we saw desexualization by public and private actors challenging the mandated coverage of contraceptives. In terms of emergency contraception, we see desexualization in the actions of regulatory officials. In both contexts, desexualization is used to propel women toward motherhood. As a consequence, women are impliedly told prior to intercourse that sex is only sanctioned if it is done for the purposes of becoming a parent, thus further facilitating the legal regulation of sexual and reproductive decisionmaking.

III. The Curious Disappearance of the Pregnant Woman: Using Rituals to Promote Motherhood[148]

Motherhood is treated as a "female rite of passage" that marks a woman's value and status.[149] For a woman, rejecting motherhood is tantamount to rejecting her core societal role.[150] Using contraceptives is counter to the role women are supposed to play.

Whether a woman seeks to end a pregnancy or to continue it, desexualization continues through the regulation of women's sexual and reproductive health.[151] After all, a less-sexual woman may be seen as a better mother.[152] But being pregnant does not necessarily mean that one will become a "mother," let alone the good, all-sacrificing mother that society demands. Manufacturing mothers after conception also requires what this Article calls ritualization: first, making pregnant women seeking an abortion participate in the same medical rituals that women continuing pregnancies are directed to undertake, and second, for women who decide to continue their pregnancy, using their participation or lack of participation in certain rituals to indicate whether they will be "good mothers." Desexualization and ritualization work in tandem in reproductive health law to cast women as mothers.

Pregnancy Caused by Rape, Indiana Candidate Says, Nat'l Pub. Radio (Oct. 24, 2012, 7:15 AM), http://www.npr.org/blogs/thetwo-way/2012/10/24/163529166/god-intended-a-pregnancy-caused-by-rape-indiana-candidate-says. *But see* Goldstein, *supra* note 12, at 13 (saying that rape victims may not be expected to take on the mothering role because they did not consent to having sex).

148. Another area of ritualization is infertility treatment. For an exploration of the relationship between abortion jurisprudence and assisted reproductive technology, see generally Burkstrand-Reid, *The More Things Change*, *supra* note 68, and Jody Lyneé Madeira, *Woman Scorned?: Resurrecting Infertile Women's Decision-Making Autonomy*, 71 Md. L. Rev. 339 (2012).

149. Martha McMahon, Engendering Motherhood: Identity and Self-Transformation in Women's Lives 108 (1995).

150. *Id.* at 231.

151. Robbie E. Davis-Floyd, Birth as an American Rite of Passage 61 (2003).

152. Friedman et al., *supra* note 66, at 796–99.

A. Locating and Defining Ritualization

"Good motherhood" is derived from a cultural script telling women how to be mothers.[153] This script requires women to relegate their sexuality to the periphery.[154] Rituals bring women into the norms of pregnancy and motherhood.[155] Women may be coerced into participating in what are typically treated in continuing pregnancies as bonding rituals associated with "good motherhood."[156] In the context of abortion, by requiring women to interact with providers multiple times or see an ultrasound, the law tries to compel them to accept the role of mother.[157] Likewise, women are told by society and the legal system that to be a "good mother" they must participate in a medicalized birth and may be legally punished if they do not.[158]

This Part examines how ritualization underpins the regulation of pregnant women's sexual and reproductive health decisionmaking and thus undermines women's autonomy once a woman is pregnant.[159] Ritualization occurs both in the context of abortion and in the context of a continuing pregnancy, from prenatal care to childbirth. In both, we see examples of how *Roe* and its progeny have been mobilized to facilitate the State's purported interest in "maternal" health and fetal life, which thinly veils how the law pushes women toward motherhood.[160]

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153. McMahon, *supra* note 149, at 27.

154. Montemurro & Siefken, *supra* note 6, at 366; Tardy, *supra* note 6, at 462–63.

155. Lisa M. Mitchell, Baby's First Picture: Ultrasound and the Politics of Fetal Subjects 174 (2001); Geoffrey P. Miller, *The Legal Function of Ritual*, 80 Chi.-Kent L. Rev. 1181, 1181, 1189–90 (2005) ("Rituals . . . speak to people's core emotions and reveal values that a society holds dearest. Because their expression is conventional and obligatory, they join the individual in solidarity with the group. . . . Rituals are enacted at key transitions in a person's life when he or she is likely to be receptive to influences on identity. These transitions include life crises such as . . . pregnancy, parenthood, or death of a loved one. People are likely to be more receptive to influence in these situations because the circumstances tend to be charged with emotion and because these are occasions where identities are changing.").

156. *See generally* Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. Rev. 351, 382–83 (2008) [hereinafter Sanger, *Seeing and Believing*]. There are countless rituals in the medicalized birthing process today. Davis-Floyd, *supra* note 151, at 73–153 (listing, for example, the use of wheelchairs, separation from partners, use of hospital gowns instead of personal clothing, enemas, hospital beds, and fasting).

157. Sanger, *Seeing and Believing*, *supra* note 156, at 382–83.

158. The regulation of aspects of reproductive health is part of the "medicalized . . . need to protect women." Ikemoto, *The Realignment of Women's Health*, *supra* note 43, at 752; *see infra* Part II.B.; Valenti, *supra* note 25, at 158–61. The government extensively regulates the behavior of pregnant women when it comes to drug use. *See, e.g.*, Julie B. Ehrlich, *Breaking the Law by Giving Birth: The War on Drugs, the War on Reproductive Rights, and the War on Women*, 32 N.Y.U. Rev. L. & Soc. Change 381, 386–92 (2008) (examining state responses to "the perceived problem of drug use by pregnant women").

159. Using abortion jurisprudence to directly or implicitly justify intervention in women's reproductive lives is a "serious distortion" of *Roe*. Janet Gallagher, *Prenatal Invasions & Interventions: What's Wrong with Fetal Rights*, 10 Harv. Women's L.J. 9, 15 (1987); *see* Kim Shayo Buchanan, Lawrence v. Geduldig: *Regulating Women's Sexuality*, 56 Emory L.J. 1235, 1291 (2007) ("[T]he courts of appeals of two circuits have imported the 'undue burden' standard to adjudicate the equal protection rights of pregnant women in cases that have nothing to do with any countervailing state interest in protecting fetal life.").

160. *Roe* is cited in reproductive and sexual health cases outside of the abortion context. *See, e.g.*, Carey v. Population Control Servs. Int'l, 431 U.S. 678, 685–90 (1977); Leigh v. Bd. of Registration in Nursing, 506

The number and type of abortion-related laws are extensive and continue to increase.[161] Some of these laws contain an insidious aspect: they replicate the rituals of prenatal care but with the goal of stopping women from exercising their right to have an abortion. Examples of common abortion laws that both limit access to abortion care and replicate prenatal care are forced ultrasounds, biased counseling, and mandatory delay laws, which operate together to ritualize abortion services.

1. Forced Ultrasounds[162]

Perhaps the most powerful ritual in a continuing pregnancy is displayed on a screen and subsequently carried in the pockets and purses of mothers-to-be. This is the ultrasound, the first visual representation of a fetus.[163] Ultrasounds have become a rite of passage for a pregnant woman.[164] This prenatal ritual is one of many legal tools that anti-reproductive-rights advocates use to push women seeking abortions toward motherhood.[165]

Ultrasound use is virtually unregulated in the United States, and the research on the safety and efficacy for both the pregnant woman and fetus is limited.[166] Even in a continuing pregnancy, ultrasounds are medically indicated only in limited circumstances.[167] Ultrasounds in a continuing pregnancy can be used to confirm that the pregnancy is viable, determine the date of gestation and the number of fetuses, and to determine whether there may be problems with the fetus.[168] During the ultrasound process, women may hear a fetal heartbeat and may leave their provider's office with a printout of a bean-sized image to share with friends and family.[169] Despite the popularity of this ritual,

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N.E.2d 91, 94 (Mass. 1987); Sammon v. N.J. Bd. of Med. Exam'rs, 66 F.3d 639, 646 (3d Cir. 1995); Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. Health Pol. Pol'y & L. 299, 325 (2013).

161. *States Enact a Record Number of Abortion Restrictions in 2011*, Guttmacher Inst. (Jan. 5, 2012), http://www.guttmacher.org/media/inthenews/2012/01/05/endofyear.html.

162. Elective cesarean sections are beyond the scope of this Article. For points of view on this procedure, see Veronique Bergeron, *The Ethics of Cesarean Section on Maternal Request: A Feminist Critique of the American College of Obstetricians and Gynecologists' Position on Patient-Choice Surgery*, 21 Bioethics 478, 482–84 (2007); Gene Declercq & Judy Norsigian, *Mothers Aren't Behind A Vogue for Caesareans*, Boston Globe (Apr. 3, 2006), http://www.boston.com/yourlife/health/women/articles/2006/04/03/mothers_arent_behind_a_vogue_for_caesareans.

163. Carol Sanger, "*The Birth of Death": Stillborn Birth Certificates and the Problem for Law*, 100 Calif. L. Rev. 269, 282 (2012).

164. *Id.* at 282.

165. Sanger, *supra* note 163, at 301–02.

166. *Compare*, Ina May Gaskin, Ina May's Guide to Childbirth 191 (2003), *with* Murkoff & Mazel *supra* note 139.

167. Gaskin, *supra* note 166, at 191. *But see* Tex. Med. Providers Performing Abortion Servs. v. Lakey, 667 F.3d 570, 579 (5th Cir. 2012) (describing sonograms as "routine measures in pregnancy medicine today" and "'medically necessary' for the mother and fetus").

168. Murkoff & Mazel, *supra* note 139, at 60; Gaskin, *supra* note 166, at 191.

169. *Forming a Bond with Your Baby—Why It isn't Always Immediate*, WebMD (Aug. 2, 2012), http://www.webmd.com/parenting/baby/forming-a-bond-with-your-baby-why-it-isnt-always-immediate ("[Bonding] begins to happen even before the baby is born—when you feel the first little flutters in your belly

the ultrasound process and resulting "picture" are misleading; especially early in pregnancy, it is likely that "the ultrasound image has been magnified and the heartbeat amplified."[170] Studies show that most couples need help even interpreting the fetal image.[171] So why is that black-and-white printout so powerful? Quite simply: the act of holding that picture defines the holder as a parent.[172]

There are limited medical reasons to require an ultrasound for a first-trimester abortion.[173] Some providers perform ultrasounds voluntarily, however, while others are forced by law to either perform them or to give information about them prior to providing an abortion.[174] Regardless of whether the ultrasound is mandated by law or performed at the direction of the provider, ultrasounds push women toward motherhood.

Some states do not require a provider to perform an ultrasound but require providers to offer to display the ultrasound screen if one is performed.[175] In some states, the law forces a woman seeking an abortion to have an ultrasound—regardless of her or the provider's wishes—and may require the provider to offer to show the image to the woman.[176] State laws with the most "force" require providers to perform an ultrasound, display the image, and describe what is on the screen,[177] presumably on the patriarchal assumption that women having an abortion have not thought their choice through.[178]

Ultrasound laws are often veiled in medical terms and are described as a type of "informed consent."[179] Informed consent in medicine, generally, is

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or see your baby kick on the ultrasound screen."); Kukla, *supra* note 25, at 70–74 (describing ultrasounds as being "social" events).

170. Caroline Mala Corbin, *Compelled Disclosures*, Ala. L. Rev. (forthcoming 2014), at *45, *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2258742.

171. Mitchell, *supra* note 155, at 5.

172. *10 Ways to Bond With Your Bump*, Babycentre (last updated Oct. 2011), http://www.babycentre.co.uk/a1049630/10-ways-to-bond-with-your-bump#ixzz2GwTNBzGD ("Having a picture of your baby's scan on your phone or on your fridge door is a constant reminder that your bump is home to a little person.").

173. Sarah E. Weber, *An Attempt to Legislate Morality: Forced Ultrasounds as the Newest Tactic in Anti-Abortion Legislation*, 45 Tulsa L. Rev. 359, 380 (2009); *2011 Clinical Policy Guidelines*, Nat'l Abortion Fed'n, at 9–10 (2011), http://www.prochoice.org/pubs_research/publications/downloads/professional_education/2011%20CPGs.pdf.

174. *State Policies in Brief: Requirements for Ultrasound*, Guttmacher Inst., http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf (last visited Oct. 6, 2013).

175. *See, e.g.*, Ohio Rev. Code Ann. § 2317.561 (West 2008); W. Va. Code § 16-2I-2(c) (2010).

176. *See, e.g.*, Ala. Code § 26-23A-4(b)(4) (2002); Fla. Stat. § 390.0111(3)(a) (2013).

177. *See, e.g.*, La. Rev. Stat. Ann. § 40:1299.35.2(D) (2012). In some circumstances, a woman may opt to look away or decline to listen. *State Policies in Brief*, *supra* note 174.

178. *See, e.g.*, Tex. Med. Providers Performing Abortion Servs. v. Lakey, 667 F.3d 570, 573 (5th Cir. 2012) (providing the title of the Texas anti-abortion and ultrasound statute—the "Woman's Right to Know Act"). However, information that "might cause the woman to choose childbirth over abortion" does not in and of itself make a law unconstitutional. Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 883 (1992).

179. *See, e.g.*, *Tex. Med Providers Performing Abortion Servs.*, 667 F.3d at 582; La. Rev. Stat. Ann. § 40:1299.35.2(D)(2)(d) (requiring women to fill out a form indicating that they've been given the opportunity

designed to be a health protection for patients, but the use of ultrasounds and the required dialogue surrounding their use prior to abortion is intended to push women toward motherhood.[180] Even if forced ultrasounds are constitutionally permissible, their purported constitutionality does not make them any more medically necessary or any less political.[181]

Mandating ultrasounds in the context of abortion care uses a major ritual of a continuing pregnancy in an attempt to trigger "maternal" bonding, prompt "maternal" guilt, and prevent abortion.[182] The very process of getting an ultrasound is part of the ritual of a continuing pregnancy: the cleaning of the stomach, the movement of the ultrasound wand, lying down on what may feel like a delivery table, lights dimmed and screen bright.[183] It is in similar circumstances when, later in a continuing pregnancy, women may find out the sex of the baby and have the first glimpse of fetal body parts and the twists and turns of the fetus in utero. As such, the law tries to turn them into mothers; ultrasounds put the pregnant woman in a place very similar to where she might be in a much later point in pregnancy, one at which, hypothetically, she has accepted motherhood. It is a thinly "veiled attempt to personify the fetus and dissuade a woman from obtaining an abortion."[184]

2. Biased Counseling/Informed Consent and Mandatory Delay/Waiting Periods

While the use of forced ultrasounds may be the most obvious way that a ritual of continuing pregnancy is used to push women seeking an abortion into motherhood, ritualization is used in other ways in the context of abortion. Although more subtle, some counseling and informed consent provisions regulating abortion also signify ritualization and further thrust women toward motherhood.[185]

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to see the "unborn child" and listen to a heartbeat); Sonia M. Suter, *Bad Mothers or Struggling Mothers?*, 42 Rutgers L.J. 695, 700 (2011).

180. Suter, *supra* note 179, at 700.

181. *Tex. Med Providers Performing Abortion Servs.*, 667 F.3d at 576.

182. Sanger, *Seeing and Believing*, *supra* note 156, at 382–83.

183. Mitchell, *supra* note 155, at 3; Michelle Chen, *It's Not Just Forced Ultrasound: Abortion Rights Under Assault*, Salon (Oct. 21, 2012, 12:00 PM), http://www.salon.com/2012/10/21/its_not_just_forced_ultrasound_abortion_rights_under_assault. Furthermore, given the high percentage of women having abortions who are already mothers, by replicating the ultrasound ritual, the law has compelled women to experience a significant ritual in "maternal" healthcare and "motherhood," one which they may be familiar with as biological mothers. Lauren Sandler, *The Mother Majority: Women with Children Have More Abortions than Anyone Else, and By an Increasingly Wide Margin. So Why is the Topic Taboo?*, Slate (Oct. 17, 2011, 4:34 PM), http://www.slate.com/articles/double_x/doublex/2011/10/most_surprising_abortion_statistic_the_majority_of_women_who_ter.html.

184. *State Policies in Brief*, *supra* note 174.

185. Chinué Turner Richardson & Elizabeth Nash, *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials*, 9 Guttmacher Pol'y Rev. 4 (2006) ("In some cases, the state goes so far as to include information that is patently inaccurate or incomplete, lending credence to the charge that states'

The State may express anti-abortion viewpoints by forcing medical providers to convey information that goes beyond traditional informed consent requirements.[186] Thirty-five states require that women receive some type of counseling prior to having an abortion; twenty-seven specify what the information must include, and that information is often biased or inaccurate.[187] These laws are often described as "informed consent" laws, a label that disingenuously implies that they replicate the counseling that takes place before all medical procedures when, in fact, the information provided goes far beyond that. This is why pro-choice advocates sometimes call them "biased counseling" laws.[188] For example, South Dakota forces providers to give misleading information that says having an abortion puts women at increased risk of committing suicide.[189] Wisconsin requires that the materials offered to a woman include "photographs, pictures or drawings, that are designed to inform the woman of the probable anatomical and physiological characteristics of the unborn child at 2-week gestational increments."[190] Some states even provide inaccurate information on the impact an abortion can have on future fertility[191] and the discredited theory that there is a link between abortion and breast cancer.[192]

To understand how biased counseling constitutes ritualization at the time of an abortion, one must first understand how health care is delivered during a

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abortion counseling mandates are sometimes intended less to inform women about the abortion procedure than to discourage them from seeking abortions altogether.").

186. Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 882–83 (1992) ("If the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible . . .[R]equiring that the woman be informed of the availability of information relating to fetal development and the assistance available should she decide to carry the pregnancy to full term is a reasonable measure to ensure an informed choice, one which might cause the woman to choose childbirth over abortion. This requirement cannot be considered a substantial obstacle to obtaining an abortion, and, it follows, there is no undue burden.").

187. *State Policies in Brief: Counseling and Waiting Periods for Abortion*, Guttmacher Inst., http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf (last visited Oct. 6, 2013) [hereinafter *Counseling and Waiting Periods for Abortion*]. Counseling may be oral or written, in person or not. *Id*; *see* Caroline Mala Corbin, *The First Amendment Right Against Compelled Listening*, 89 B.U. L. Rev. 939, 1000–11 (2009) (arguing that women have a right to not listen to abortion-related counseling).

188. *See Biased Counseling & Mandatory Delays*, NARAL Pro-Choice Am., http://www.prochoiceamerica.org/what-is-choice/fast-facts/biased_counseling.html (last visited Oct. 14, 2013) (defining "biased counseling" and "mandatory delay"); *see also Counseling and Waiting Periods for Abortion*, *supra* note 187; Ian Vandewalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, 19 Mich. J. Gender & L. 1, 6–33 (2012).

189. Planned Parenthood Minn., N.D., & S.D. v. Rounds, 686 F.3d 889, 905 (8th Cir. 2012); *Spurious Science Triumphs as U.S. Court Upholds South Dakota "Suicide Advisory" Law*, Guttmacher Inst. (July 27, 2012), http://www.guttmacher.org/media/inthenews/2012/07/27/index.html (quoting the American Psychological Association as saying, "the best scientific evidence indicates that the relative risk of mental health problems among adult women who have an unplanned pregnancy is no greater if they have an elective first-trimester abortion than if they deliver the pregnancy").

190. Wis. Stat. § 253.10 (3)(d)(2) (2012).

191. *Counseling and Waiting Periods for Abortion*, *supra* note 187 (listing Arizona, Kansas, North Carolina, South Dakota, Texas, and West Virginia).

192. *Id.* (listing Alaska, Kansas, Mississippi, Oklahoma, and Texas).

typical pregnancy. In an ideal prenatal care setting, when a woman chooses to continue a pregnancy, her interaction with a medical professional begins immediately. In addition to confirming the pregnancy, the first visit typically involves the taking of a medical history, a physical exam, some laboratory tests, a lot of talk about what is to come in the next several months, and ways for the pregnant woman to stay healthy during the pregnancy.[193]

Biased counseling laws are an attempt to replicate that prominent ritual of pregnancy: visits to a trusted healthcare provider.[194] But abortion "informed consent" statutes do nothing of the kind; they twist the woman's medical confidant into an ideological advocate, whether or not the provider agrees.[195] As a consequence, a woman's trust in her provider is used against her.

Admittedly, when a pregnancy is to be terminated, a woman's relationship with the provider is more truncated than the relationships women have with their providers in an ongoing pregnancy.[196] Nonetheless, by requiring biased counseling, the State pushes healthcare providers to exert power over a woman seeking to end a pregnancy. The power a practitioner has over a pregnant woman, whether she is ending or continuing her pregnancy, is immense[197] and is badly misused when counseling is biased, especially when that provider is forced to provide erroneous health information.[198] But biased counseling is not the only example of ritualization in pregnancy. Mandatory delay laws, which require time to pass between an initial consultation and the abortion, also mimic the care provided in a wanted pregnancy.

Monthly visits to a medical provider are one of the rituals of an ongoing pregnancy.[199] The wait between each visit provides time for the pregnant woman (transformed into a mother) to bond with the fetus and to contemplate motherhood.[200] This process is mirrored to a limited extent by laws that mandate delay between a woman's decision to have an abortion and the procedure itself. In twenty-six states, a woman has to wait one or more days between the time she seeks an abortion and the time an abortion is performed,

193. Murkoff & Mazel, *supra* note 139, at 124–26.

194. *Compare id.* at 21–32, *with* La. Rev. Stat. Ann. § 40:1299.35.6(A)(4)(c) (2012).

195. Richardson & Nash, *supra* note 185.

196. La. Rev. Stat. Ann. § 40:1299.35.6(A)(4)(c) ("The vast majority of all abortions are performed in clinics devoted solely to providing abortions and family planning services. Most women who seek abortions at these facilities do not have any relationship with the physician who performs the abortion, before or after the procedure. They do not return to the facility for postsurgical care. In most instances, the woman's only actual contact with the physician occurs simultaneously with the abortion procedure, with little opportunity to receive counseling concerning her decision.").

197. *See, e.g.*, M.C. Shapiro et al., *Information Control and the Exercise of Power in the Obstetrical Encounter*, 17 Soc. Sci. Med. 139, 145 (1983).

198. Vandewalker, *supra* note 188, at 6–33.

199. *See generally* Murkoff & Mazel, *supra* note 139 (describing monthly prenatal visits).

200. *Id.* at 29, 248; Sara Terzo, *Analysis: Pro-Life Support for Abortion Waiting Periods and Informed Consent Saves Lives*, Live Action News (Jan. 20, 2013), http://liveactionnews.org/pro-life-support-for-abortion-waiting-periods-and-informed-consent-saves-lives.

and several states mandate two visits to the abortion provider.[201] A woman terminating a pregnancy is required to take the time to think about and bond with her "unborn child," as if she had not already seriously considered her decision to have an abortion before going to visit her provider.

Forced ultrasounds, biased counseling, and mandatory delay laws replicate rituals that take place during the process preceding childbirth for the purpose of making women accept the role of mother, and thus impede women's access to abortion. The information presented to the woman—via ultrasound, orally, or in writing—is designed to create a hierarchical relationship with a medical professional who then may be required to provide information designed to induce women to feel like a mother through these rituals and create feelings of guilt about choosing not to be a mother. If a woman does not change her mind, she is rejecting "a five-thousand-year-old tide of conditioning, of social agendas propounded by churches and other male-dominated institutions, that say that a woman's primary purpose is to have children and to serve her children and her husband."[202]

B. The Patient Mother

One might think that once a woman accepts the responsibility of childbirth, the State would cease to intervene. But "choice" is not just about abortion. Pregnancy and the birth process are filled with a vast number of options regarding how birth will take place.[203] And the law frequently influences what choices women make as mothers, as we see through the ritualized practices in the ongoing pregnancy.

In the context of childbirth, ritualization involves a woman engaging the rituals of a medicalized pregnancy and birth process, primarily the rituals involved in standard obstetric care and hospital birthing.[204]

> By 'medicalizing' birth, i.e. separating a woman from her own environment and surrounding her with strange people using strange machines to do strange things to her in an effort to assist her, the woman's state of mind and body is so altered that her way of carrying through this intimate act must also be altered and the state of the baby born must equally be altered. The result is that it is no longer possible to know what births would have been like before these manipulations. Most health care providers no longer know what

201. *Counseling and Waiting Periods for Abortion*, *supra* note 187. Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 885–87 (1992) (upholding a twenty-four hour waiting period). Although some states require a mandatory delay of less than twenty-four hours, the practical impact of the delay is likely to make the woman have to return to the provider the following day.

202. Christiane Northrup, Women's Bodies, Women's Wisdom: Creating Physical and Emotional Health and Healing 388 (2010).

203. Murkoff & Mazel, *supra* note 139, at 21–31.

204. This Article asserts that ritualization is reflected in the broader trend of medicalization, the "process of turning . . . people into patients. . . . It leads people to have too much treatment—and some of them are harmed by it." H. Gilbert Welch, Opinion, *The Medicalization of Life*, L.A. Times (Mar. 15, 2010), http://articles.latimes.com/2010/mar/15/opinion/la-oe-welch15-2010mar15.

> 'non-medicalized' birth is. The entire modern obstetric and neonatological literature is essentially based on observations of 'medicalized' birth.[205]

Although women can give birth in a variety of settings, they do so overwhelmingly in hospitals and with physicians, though options for other birth attendants exist.[206] In the United States there is a "veritable mandate" that babies be born in hospitals—and nearly all are.[207] This is due, in part, to the increasing number of medical technologies that are presented as necessary for a safe labor process: fetal monitors and intravenous medicines, among other interventions, are part of the birth ritual.[208] Given all of the technology now available for use during the labor process, its use is expected; women who refuse modern locations, modern interventions, or who forsake "scientific" (that is physician) advice risk being seen as selfish, the hallmark of a "bad mother."[209]

Some degree of medicalization within the narrow relationship between a pregnant woman and her practitioner is expected. But our legal regime may go above and beyond the typical provider-patient relationship by dictating where, how, and with whom women may labor.[210] Why do we see ritualization in the law and social dictates regarding what constitutes a good pregnancy and birth?[211] Is it a symptom of industrialization and our societal obsession with new technologies?[212] Is it a sign not only of State intervention but also our lawsuit-happy society, with doctors choosing to intervene rather than assume legal risk?[213] Or might the State's push to use the rituals of medicalized birth reflect a distrust of women's reproductive capacity, a view "of the female body as an inherently defective machine?"[214] The answer is unknown.

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205. M. Wagner, *Fish Can't See Water: The Need to Humanize Birth*, 75 Int'l J. Gynecology & Obstetrics S25, S26 (2001) (quoting the European Reg'l Office, World Health Org., Having a Baby in Europe (1985)).

206. Joyce A. Martin et al., Dep't of Health & Human Servs., Births: Final Data for 2011, 62 Nat'l Vital Statistics Reports 1, 12 (2013).

207. Heather Joy Baker, "*We Don't Want to Scare the Ladies:" An Investigation of Maternal Rights and Informed Consent Throughout the Birth Process*, 31 Women's Rights L. Rep. 538, 553 (2010); *see supra* note 206.

208. Murkoff & Mazel, *supra* note 139, at 362–99.

209. *See* Kukla, *supra* note 25, at 74 (discussing "birth as a maternal achievement test"); Baker, *supra* note 207, at 553. *See generally* Susan Goldberg, *Medical Choices During Pregnancy: Whose Decision is it Anyway?*, 41 Rutgers L. Rev. 591 (1989) (discussing efforts to compel pregnant women to undergo treatments against their wishes). Blaming the woman for all ills that befall her baby is not new; for example, people used to believe that "if you looked at ugly things, you'd have an ugly baby." Tara Parker-Pope, *Lessons from the History of Childbirth*, N.Y. Times (Well) (Feb. 5, 2010, 10:28 AM), http://well.blogs.nytimes.com/2010/02/05/the-history-of-childbirth. For a discussion of the "bad mother" in law, see generally Marie Ashe, *The "Bad Mother" In Law and Literature: A Problem of Representation*, 43 Hastings L.J. 1017 (1992).

210. The tort system may impact obstetrical practice. Sheila Kitzinger, The Complete Book of Pregnancy & Childbirth 56 (2011); Davis-Floyd, *supra* note 151, at 48.

211. Jennifer Block, Pushed: The Painful Truth About Childbirth and Modern Maternity Care 6 (2007); Davis-Floyd, *supra* note 151, at 48.

212. Block, *supra* note 211, at 6, 39–40.

213. *Id.* at 43; Davis-Floyd, *supra* note 151, at 48.

214. Davis-Floyd, *supra* note 151, at 72.

The State controls pregnancy and labor by propelling pregnant women toward a birth marked by a standard set of medical rituals. Specifically, it adopts laws and allows legal interventions that (1) limit what type of medical professional can attend childbirth, (2) limit the locations of birth labor, and (3) limit the methods women use to give birth. All of these exemplify how women are expected to participate in the ritualization of pregnancy, the propulsion of those women toward "good motherhood," and the consequences to women who do not participate in these rituals.[215]

1. Attending Birth

Among the most important decisions a woman approaching childbirth can make is the choice of who, if anyone, will provide medical attention to her and the child at birth. This choice is circumscribed by legal restrictions limiting the number of acceptable choices available to a "good mother."

> In medicalized birth the doctor is always in control while the key element in humanized birth is the woman in control of her own birthing and whatever happens to her. No patient has ever been in complete control in the hospital—if a patient disagrees with the hospital management and has failed in attempts to negotiate the care, her only option is to sign herself out of the hospital. Giving women choice about certain maternity care procedures is not giving up control since doctors [decide] what choices women will be given and doctors still have the power to decide whether or not they will acquiesce to a woman's choice.[216]

More than eighty-six percent of all hospital births are attended by physicians, who are often criticized as being proponents of medicalized birth.[217] A recent trend in birth choice in the United States is to eschew the services of a physician and use alternative providers—midwives—to facilitate a kinder, more gentle birth.[218] There are several types of midwives, and each has different legal status, degree of legal regulation, educational requirements, and type of organization.[219] Even though many Certified Nurse Midwives, one type of midwife, practice in hospitals,[220] they are seen by some as a viable alternative to the medicalization of birth.[221] Still, many fewer hospital births are attended by midwives as compared with physicians,[222] even though studies

215. The treatment of pregnant women may vary depending upon the pregnant woman's social status. Michele Goodwin, *Prosecuting the Womb*, 76 Geo. Wash. L. Rev. 1657, 1661–64 (2008) (outlining the discriminatory application of drug-related laws to pregnant women).

216. Wagner, *supra* note 205, at S26.

217. Martin et al., *supra* note 206, at 12; Block, *supra* note 211, at 263.

218. This is not to say that all physicians subscribe to a medicalized view of birth, or that all midwives do not. Gaskin, *supra* note 166, at 305–07.

219. For detailed information on the types of midwives, see *Comparison of Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives*, Am. Coll. of Nurse-Midwives (Mar. 2011).

220. Martin et al., *supra* note 206, at 12–13.

221. Murkoff & Mazel, *supra* note 139, at 24–25; Gaskin, *supra* note 166, at 305–07; Rebecca A. Spence, *Abandoning Women to Their Rights: What Happens When Feminist Jurisprudence Ignores Birthing Rights*, 19 Cardozo. J.L. & Gender 75, 93 (2012).

222. Martin et al., *supra* note 206, at 12.

suggest that births attended by midwives (as well as births at home) are as safe as or safer than physician-assisted births for women with uncomplicated pregnancies.[223] But midwives face a patchwork of legal regulations.[224]

In midwifery-related jurisprudence, *Roe* has been used by courts as both sword and shield against pregnant women. For example, one court wrote that *Roe* and its progeny provide no privacy protection for women wanting midwives, thus limiting access to such providers: "The right to privacy which protects a woman's choice to have an abortion has never been interpreted to guarantee a woman the right to choose the manner and circumstances in which her baby is born."[225] Another court used *Roe* to find a legitimate state interest in regulating midwifery and limiting access to midwives.[226] Thus, once the woman has had sex that leads to procreation, ritualization of birth seals the deal: as a mother-to-be she is desexualized and pregnancy and birth rituals further entrench her in her socially and legally defined role as a mother.

As discussed previously, *Roe*'s applicability to women's health issues outside of the abortion context—including midwifery—is questionable. This is, in part, because it is unclear what parts of *Roe* are essential holdings and what parts are dicta.[227] *Roe* states that it is permissible to regulate the qualifications of the abortion provider, the location of the procedure, and the applicable licensing requirements, but this approval is given in the context of abortion services, and it does not speak to any extension of the holding outside of that factual context.[228] Nonetheless, some in the midwifery community appear to concede that an expansive reading of *Roe* supports arguments to curtail or regulate midwifery.[229]

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223. Christopher Rausch, *The Midwife and the Forceps: The Wild Terrain of Midwifery Law in the United States and Where North Dakota is Heading in the Birthing Debate*, 84 N.D. L. Rev. 219, 227–30 (2008).

224. For detailed information, see *Comparison of Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives*, *supra* note 219. Additionally, midwives may have difficulty with insurance reimbursement, finding physicians willing to supervise their practice, or getting hospital privileges. Susan Corcoran, *To Become a Midwife: Reducing Legal Barriers to Entry into the Midwifery Profession*, 80 Wash. U. L.Q. 649, 651 (2002).

225. Leigh v. Bd. of Registration in Nursing, 506 N.E.2d 91, 94 (Mass. 1987).

226. Sammon v. N.J. Bd. of Med. Exam'rs, 66 F.3d 639, 646 (3d Cir. 1995).

227. *See* Randy Beck, *Self-Conscious Dicta: The Origins of* Roe v. Wade*'s Trimester Framework*, 51 Am. J. Legal History 505, 506–08 (2011).

228. Roe v. Wade, 410 U.S. 113, 163 (1973).

229. One person in the midwifery community said that "[i]n short, if a state can require persons performing abortions to be licensed doctors, then a state can require that persons assisting births be licensed doctors, nurses or midwives as well. This is why midwifery proponents should never argue that *Roe v. Wade* supports a mother's right to choose her manner and place of giving birth. . . . Because midwifery involves the birth of a child after viability, assisted by a nonphysician, *Roe v. Wade* is not good precedent for a privacy argument." Erik L. Smith, *Midwifery and the Constitution*, 65 Midwifery Today 33, 35 (2003). For an examination of *Roe*'s impact in other non-abortion contexts, see generally Susan Behuniak-Long, Roe v. Wade*: The Impact of An Outdated Decision on Reproductive Technologies*, 8 Pol'y Studies Rev. 368 (1989).

Restrictions on midwifery are based on the ritualized treatment of labor as a medical condition.[230] As in abortion jurisprudence, even before birth, women are treated as mothers whose first priority is their baby, not as women who can make autonomous healthcare decisions.[231] Legal barriers to midwifery have the attendant consequence of driving women into the traditional healthcare system, where technology is omnipresent and where "good mothers" take advantage of it.[232] These medicalized rituals are a welcome aspect of birth for some women, yet for those who seek an alternative path to childbirth, even one that has been shown to be safe for mother and fetus, rejection of prescribed rituals opens the door to further legal limits on reproductive autonomy, such as where the birth can take place and what type of birth—vaginal or cesarean—will occur.

2. Locating Birth

The location of birth is closely linked to who attends birth.[233] Again, the location of birth triggers the State's interest in "maternal" health as conceptualized in abortion regulation and, thus, ritualization is present. And again, this regulation of "motherhood" takes place before a woman actually becomes a mother.

Although nearly one hundred percent of births took place in a hospital in 2011,[234] not all women want hospital births; some women seek to give birth at a birthing center or even at home. Birthing centers are typically locations where women are often attended by midwives in a setting that is less medicalized than hospitals.[235] Home birth is controversial; a 2012 study goes as far as to propose that countries should establish home birth support, as "there is no strong evidence . . . to favour either planned hospital birth or planned home birth for low-risk pregnant women."[236] But the legal ramifications of giving birth at home can be dramatic for both the pregnant woman and any medical professional who may help her.[237]

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230. Marsden Wagner, Born in the USA: How a Broken Maternity System Must Be Fixed to Put Mothers and Infants First 108 (2006); Laura D. Hermer, *Midwifery: Strategies on the Road to Universal Legalization*, 13 Health Matrix 325, 330–32, 367 (2003).

231. Lynn M. Paltrow, *Missed Opportunities in* McCorvey v. Hill*: The Limits of Pro-Choice Lawyering*, 35 N.Y.U. Rev. L. & Soc. Change 194, 221–22 (2011) (discussing the lack of concern in the law for the regret and emotion women feel when their labor and birth choices are not respected).

232. Kiki Zeldes & Judy Norsigian, *Encouraging Women to Consider a Less Medicalized Approach to Childbirth Without Turning Them Off: Challenges to Producing Our Bodies, Ourselves: Pregnancy and Birth*, 35 Birth 245, 249 (2008).

233. *See* Spence, *supra* note 221, at 92–93 ("Reproductive justice demands that all pregnant people have an equal opportunity to make and exercise decisions about their care, including out-of-hospital birth. While no state regulates the location where a woman must give birth, all states have the power to license and regulate health professionals who attend birth as a component of state police power.").

234. Martin et al., *supra* note 206, at 12.

235. Murkoff & Mazel, *supra* note 139, at 23.

236. Ole Olsen & Jette A. Clausen, *Planned Hospital Birth Versus Planned Home Birth (Review)*, Cochrane Library, Sept. 2012, at 1, 15.

237. Anna Hickman, *Born (Not So) Free: Legal Limits on the Practice of Unassisted Childbirth or Freebirthing in the United States*, 94 Minn L. Rev. 1651, 1653–54 (2010); *NFOM Frequently Asked*

Birth outside of hospitals is constrained.[238] For example, there is a significant economic barrier for women wanting home birth; even professionals who can attend such births legally are often not covered by private insurance, forcing the costs onto the pregnant woman.[239] Moreover, women can be prosecuted for their birth choice, the ultimate retribution for rejecting the traditional ritualization of birth, and some of these cases cite *Roe* in their analyses of women's reproductive rights in the context of home birth.[240] Whether one agrees with the pregnant woman's decision or not, at a minimum, the very existence of criminal prosecution may have a chilling effect on this form of non-medicalized childbirth, limiting a woman's choices. This may have the consequence of solidifying the ritual of the hospital birth.

The regulation of midwives and birth locations goes much further than the women's health regulation contemplated in *Roe*: by the point of labor, the woman has already accepted her maternal role and the inevitability of birth is no longer a concern. Still, the State influences pregnant women's choices regarding how a pregnancy should progress and thus dictates whether a pregnant woman is acting as a "good mother" when she makes those choices.[241]

The relationship between laws related to midwifery, home birth, and labor regulates women's birth choices and serves to promote a certain ritualized form of childbirth, regardless of a woman's choices: a medicalized birth. At the point of birth, women are heavily invested in the management of their own birth process, hence the emergence of so-called birth plans in which women express in writing their desires regarding how, where, and with whom childbirth is to proceed, the ultimate expression of reproductive management.[242] Yet despite these private documents, purported State interests may trump a woman's desires. When the regulations concerning where and with whom birth may occur are read together, it appears that the State is invested in the ritualization of a medicalized birth, just as it was invested in a

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Questions, Neb. Friends of Midwives, http://nefriendsofmidwives.weebly.com/ faqs.html#abouthomebirth (last visited Oct. 6, 2013) (stating that Nebraska Certified Nurse Midwives who attend a home birth purposefully may be guilty of a felony).

238. Regulations governing licensure impact women's ability to labor at home. *Home-Birth Advocates Push for Change in Laws*, NBC News (Jan. 28, 2009), http://www.nbcnews.com/ id/28901624/ns/health-womens_health/t/home-birth-advocates-push-change-laws/#.T6vcSK75878; Hickman, *supra* note 237, at 1658; Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 Cardozo Women's L.J. 61, 70 (2004). For example, many nurse-midwives must be supervised by physicians, who often will not supervise home births for liability reasons.

239. *Home-Birth Advocates Push for Change in Laws*, *supra* note 238.

240. Commonwealth v. Pugh, 969 N.E.2d 672, 676 (Mass. 2012) (reversing conviction of woman for involuntary manslaughter, discussing "whether a woman in the midst of unassisted [home] childbirth may be held criminally responsible for . . . 'inflicting fatal injuries on a viable and near full term fetus during the birthing process'"); United States v. Jumper, 3 Fed App'x 141, 147 (4th Cir. 2001) (saying, in the context of an involuntary manslaughter conviction, "[t]he evidence fairly supports the inference that Jumper knew that the health and life of her child were endangered by her decision to give birth at home without any aid").

241. Paltrow, *supra* note 16.

242. Murkoff & Mazel, *supra* note 139, at 294–97.

ritualized abortion process. But ritualization goes further—all the way to labor and delivery, which, if medical orders are not followed, may result in court-ordered medical intervention.

3. Accomplishing Birth

In some circumstances, labor does not culminate in vaginal birth; rather, a baby may be born by cesarean section, a procedure by which the baby is removed from the woman via an incision into her uterus.[243] Once uncommon, the percentage of cesareans in the United States was almost thirty-three percent in 2011,[244] more than double the estimated maximum safe percentage of cesarean births set by the World Health Organization and United States health agencies; many cesarean sections, therefore, are likely unnecessary.[245] Cesarean sections are not without risk: many minor complications, such as infection, are possible and, most significantly, cesarean birth presents higher maternal death rates than vaginal delivery.[246]

Cesarean sections are becoming a cornerstone of ritualized birth: not having one can exemplify bad "motherhood."

> As long as she has formally consented to Cesarean surgery, the case is assumed to be an easy one: her decision should be effectuated. When she has refused, however, the question becomes whether the state can override that choice. Conventional legal analyses thus pose questions such as: 1) Does the right to decide *whether* to procreate necessarily imply a right to decide *how* to procreate?; 2) Does the state's interest in the life and health of a full-term fetus outweigh the woman's right to refuse medical treatment?; 3) Does the duty of a parent to rescue a child in danger extend to a mother carrying a full-term fetus? Does it apply even when the rescue involves a risk of death to the mother?[247]

Discussing what type of birth constitutes ritualization is complex. Certainly the high rate of cesarean sections suggests that, increasingly, the correct ritual in terms of medicalization and being a "good mother" may be a cesarean section in some circumstances. Legal decisions have made clear that in some cases, the State thinks "mother" does *not* know best when it comes to birth choice. In the context of abortion, for example, the *Casey* Court says, "[n]or can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision."[248] Imagine, then, any court's reaction to a mother-to-be deciding against having a cesarean section when told to have one by a medical professional.

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243. Our Bodies, Ourselves, *supra* note 102, at 424–27.

244. Martin et al., *supra* note 206, at 13.

245. Denise Grady, *Caesarean Births Are at a High in the U.S.*, N.Y. Times (Mar. 23, 2010), http://www.nytimes.com/2010/03/24/health/24birth.html.

246. Gaskin, *supra* note 166, at 288–89.

247. Ehrenreich, *supra* note 37, at 497.

248. *See* Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 833, 882 (1992).

In several cases, laboring or critically ill women have been forced to have a cesarean section by court order. In one example, a pregnant woman was forcibly restrained and drugged under the watch of a horrified partner when she refused a cesarean section in favor of a vaginal delivery.[249] Other women have gone into hiding to avoid State-compelled cesarean sections,[250] and refusal to have a cesarean, even when the child is subsequently born healthy, has been considered in abuse and neglect proceedings.[251]

In compelled cesarean section cases, the law that is supposed to protect women's reproductive choices, at least in the context of abortion, *Roe*, may actually be used against women when they choose a birth strategy that is contrary to the provider's suggestions.[252] Again, on its surface, *Roe's* simultaneous interest in "maternal" health and fetal life may seem applicable in situations where a court forces a woman to have a cesarean section—especially given the proximity of the woman to motherhood. Seemingly, if a woman aborting a fetus is "maternal" in *Roe*, so too would be a woman approaching birth. However, courts forcing women to have cesarean sections use *Roe* to amplify the woman's function as mother and the necessity of State intervention because of her failure to assume a maternal role for the benefit of the *fetus*.[253] Whether sex was initially for pleasure or procreation, once pregnant, the woman is viewed as a mother and is expected to participate in the rituals surrounding that role accordingly. That is what a "good mother" does.

The expanded use of cesarean sections exemplifies shifts in how society sees childbirth, shifts that can "evolve into normalized practices, not only normalizing the obstetrical interventions but also their underlying assumptions about women's emotional and physiological insufficiency in labor and delivery."[254] So, in the context of forced cesarean sections, the law may not only reflect judgments of the labor-related decisions women make, but also the physical capacity of women to labor without paternalistic direction from the State.

IV. The Future of Women's Health Regulation?

Desexualization and ritualization have served both as signals and, arguably, tools of State intervention in women's health, but how might

249. *See, e.g.*, Marguerite A. Driessen, *Avoiding the Melissa Rowland Dilemma: Why Disobeying a Doctor Should Not Be A Crime*, 10 Mich. St. U. J. Med. & L. 1, 35–37 (2006) (describing the compelled cesarean section of a Nigerian woman, whose husband later killed himself).

250. Charity Scott, *Resisting The Temptation to Turn Medical Recommendations into Judicial Orders: A Reconsideration of Court-Ordered Surgery for Pregnant Women*, 10 Ga. St. U. L. Rev. 615, 674 (1994).

251. N.J. Div. of Youth & Family Servs. v. V.M., 974 A.2d 448, 449–52 (N.J. Super. Ct. App. Div. 2009).

252. Paltrow & Flavin, *supra* note 160, at 325.

253. *Id.* Another argument is that the State interest in maternal health is so strong that it overwhelms the woman's interest in autonomy. This, however, is not borne out in case law, which focuses on fetal health. *See generally* Burkstrand-Reid, *The Invisible Woman*, *supra* note 51 (discussing the minimization of the health risks of cesarean sections).

254. Bergeron, *supra* note 162, at 486.

desexualization and ritualization be used in the future? To an extent, these concepts rely on one another to function. While desexualization is the means by which sex is defined as solely procreative, ritualization further redefines the woman who took part in sex as a mother by treating her as one, regardless of whether she intends to carry the pregnancy to term. A woman's choice to have sex for pleasure can be devalued via desexualization, and that disapproval may be reinforced via ritualization or a woman can be subjected to ritualization as a means of devaluing her sexual choices.

Reproductive health choices in the areas of contraception, abortion, pregnancy, and birth suggest that accepting even a constructive State interest in women's reproductive health may come with a cost: the loss of autonomy concerning personal health decisionmaking. That cost may increase as State intervention increases. For example, given the State's ostensible efforts to "protect" maternal health at present, might the next step be to protect *potential* maternal health and to intervene more aggressively in women's sexual choices earlier in or prior to pregnancy?[255] If so, desexualization and ritualization in reproductive health law may boost any effort to "protect" women's health, which emphasizes why protections should be carefully scrutinized. Nonetheless, women need the law to recognize the inherent importance of women's health but must also deal with the negative consequences of what that recognition can mean for their autonomy.[256]

A. Desexualization and Ritualization Going Forward

Whether desexualization and ritualization are tools affirmatively used to manufacture mothers or to simply serve as signals that state involvement in women's health is present, they raise an important question: to what extent do we want the State to be involved in regulating, or protecting, women's health generally and women's reproductive health specifically? Two examples of the potential application of desexualization and ritualization, one in the context of contraception regulation and a second in the context of abortion legislation, show that the answer to this question is not obvious.

Contraception is one example of an area of reproductive health regulation in which we may see more desexualization and ritualization. As previously discussed, current controversies surrounding contraceptive coverage and emergency contraceptives show that expanding the availability of contraceptives is a political landmine. For example, future legislation might seek to force women to read and sign a state-authored "informed consent"

255. Although not discussed in this Article, conceptualizing women's health as maternal health may also impact women's rights in relation to assisted reproductive technology. *See generally* Burkstrand-Reid, *The More Things Change*, *supra* note 68; Jack M. Balkin, *How New Genetic Technologies Will Transform* Roe v. Wade, 56 Emory L.J. 843 (2007).

256. *See infra* Part IV.B.

document akin to those used in the context of abortion[257] at the time they receive contraceptives—emergency or otherwise. Documentation could appear on a receipt or even the electronic keypad when you swipe your card at checkout.[258] Such a regulation would be yet another way to desexualize women who have sex for pleasure by putting them through a ritual of motherhood in the form of a pseudo-medical "consultation" via the reading of state-authorized "medical" information. Moreover, such a law would mirror ones already approved by courts in the context of abortion.[259] But dismissing the utility of such a regulation out of hand may ignore a hypothetical benefit. Certainly adding an informed consent requirement could, if the information was accurate and apolitical, protect women's health to some limited extent by informing women as to the safety and efficacy of the medication.[260] However, the implication of forcing a woman to read such "informed consent"-type information is that a woman would not otherwise read about the medication or consider the risks inherent in taking such medication.

As the contraception hypothetical shows, legal intervention in women's health has costs, such as the loss of autonomy, and potential benefits, such as the provision of medical knowledge, if executed apolitically. Thus, desexualization and ritualization may not necessarily be harmful in every context. At a minimum, however, their presence should counsel further consideration of how a law with them operates.

The presence of both the benefits and detriments of desexualization and ritualization are also seen in the context of abortion. Prior to *Gonzales*, reproductive rights jurisprudence mandated exceptions to abortion restrictions when a pregnant woman's life or health was in danger, but the status of the health requirement is now uncertain.[261] Since *Gonzales*, activists have decried the shrinking of so-called "health exceptions" in abortion law.[262] Efforts to reinvigorate them, however, may come with both benefits and costs.

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257. *See, e.g.*, Ga. Code Ann. § 31-9A-3 to -4 (2013); Miss. Code Ann. §§ 41-41-33, -35 (2013); Kan. Stat. Ann. § 65-6709 (2013); *see also supra* note 187.

258. This is not to say that such a law would meet regulatory or constitutional requirements. *See, e.g.*, John Schwartz, *Oklahoma Judge Blocks Law Limiting Morning-After Birth Control*, N.Y. Times, Aug. 19, 2013, at A11.

259. *See supra* Part III.A.2.

260. Our Bodies, Ourselves, *supra* note 102, at 226 (saying that birth control pills increase the risk of blood clots, and outlining which women should not use the pill); *see* Plan B One-Step Product Leaflet, *What You Need to Know* (package insert listing possible side effects including changes in menstruation, abdominal pain, and nausea). Emergency contraceptives in particular are safe under most circumstances. *Id.* at 251–53 (noting that some medications may interfere with some emergency contraceptives).

261. B. Jessie Hill, *A Radically Immodest Judicial Modesty: The End of Facial Challenges to Abortion Regulations and the Future of the Health Exception in the Roberts Era*, 59 Case W. Res. L. Rev. 997, 1018–19 (2009) (noting that the decisions in *Ayotte* and *Gonzales* "effectively re-opened the issue of the meaning and scope of the health exception requirement").

262. *See, e.g.*, *Abortion Bans Without Exceptions Endanger Women's Health*, NARAL Pro-Choice Am. (Jan. 1, 2012), http://www.prochoiceamerica.org/media/fact-sheets/abortion-bans-no-exceptions-endanger-women.pdf.

Recently, controversy has arisen over abortion bans passed under the guise of preventing "fetal pain" during an abortion procedure: these laws are often called "Pain-Capable Unborn Child Protection" acts.[263] Fetal pain bans dramatically restrict abortion at and after the twentieth week post-fertilization and contain extremely circumscribed exceptions for women's health;[264] this effort "indefensibly jeopardizes" women's health, according the American College of Obstetricians and Gynecologists and the American Congress of Obstetricians and Gynecologists.[265] Courts have struck down some fetal pain-based bans, but they remain in effect in several states.[266]

Desexualization and ritualization are present in fetal-pain-based abortion bans. Women are turned into mothers by virtue of the fact that they are pregnant (ostensibly proving that sex was for procreation), they have carried the pregnancy for a long period of time, and, when they want to terminate the pregnancy, they are expected to subrogate their own health needs for the needs of the fetus.[267]

Fetal-pain-based bans are a prime example of the law's eroding protection of women's health.[268] The American College of Obstetricians and Gynecologists and the American Congress of Obstetricians and Gynecologists decried one fetal pain based-ban as "fail[ing] entirely to protect women for whom pregnancy poses serious health risks."[269] Certainly, the lack of adequate health exceptions in these laws has been a call-to-arms for pro-choice

263. *See, e.g.*, Ala. Code § 26-23B-1 (2013); Idaho Code Ann. § 18-501 (2013); La. Rev. Stat. Ann. § 40:1299.30.1 (2013); Neb. Rev. Stat. § 28-3,106 (2013); Okla. Stat. tit. 63 § 1-745.1 (2013). For an example of legislative statements related to fetal pain, see Kan. Stat. Ann. § 65-6722-6724 (2011) ("(a) Pain receptors (nociceptors) are present throughout the unborn child's entire body by no later than 16 weeks after fertilization and nerves link these receptors to the brain's thalamus and subcortical plate by no later than 20 weeks; (b) by eight weeks after fertilization, the unborn child reacts to touch. By 20 weeks after fertilization, the unborn child reacts to stimuli that would be recognized as painful if applied to an adult human, for example, by recoiling."); *see State Policies on Later Abortions*, Guttmacher Inst. (Aug. 1, 2013), http://www.guttmacher.org/statecenter/spibs/spib_PLTA.pdf (listing twenty-week bans and fetal pain-based bans, and defining fetal pain bans as "based on the assertion that the fetus can feel pain at 18 or 20 weeks postfertilization").

264. Twenty weeks post-fertilization is the equivalent of twenty-two weeks after the woman's last menstrual period. *State Policies on Later Abortions*, *supra* note 263. For an example of a fetal pain ban health exception, *see* Okla. Stat. tit. 63 § 1-745.5 (prohibiting the performance of an abortion if "the probable postfertilization age of the woman's unborn child is twenty (20) or more weeks, unless, in reasonable medical judgment, she has a condition which so complicates her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions. No such condition shall be deemed to exist if it is based on a claim or diagnosis that the woman will engage in conduct which she intends to result in her death or in substantial and irreversible physical impairment of a major bodily function").

265. Brief for Amici Curiae Am. Coll. of Obstetricians and Gynecologists and Am. Cong. of Obstetricians and Gynecologists in support of Appellants and Reversal, Isaacson v. Horne, 716 F.3d 1213 (9th Cir. 2013) (No. 12-16670), 2012, at 13 [hereinafter ACOG Amicus].

266. *See, e.g.*, Isaacson v. Horne, 716 F.3d 1213 (9th Cir. 2013); McCormack v. Hiedeman, 900 F. Supp. 2d 1128 (D. Idaho 2013); *State Policies on Later Abortions*, *supra* note 263.

267. *State Policies on Later Abortions*, *supra* note 263*;* ACOG Amicus, *supra* note 265, at 8–14.

268. ACOG Amicus, *supra* note 265, at 14–16.

269. *Id.* at 8.

advocates.[270] The situations of women seeking an abortion at and after twenty weeks suggests that, when it comes to women's health, these laws should be revisited to allow these abortions under a broader set of health-related circumstances.[271] But fetal pain bans demonstrate something else: in addition to focusing on the fetus, "protecting" women's health is used by states to justify reproductive health regulations when the true legislative goal is to restrict women's reproductive rights.[272] Case in point: the argument made in one case that later-term abortions pose greater health risks to pregnant women than do earlier abortions, thereby justifying the ban.[273] These types of arguments are disingenuous at best.[274] Every complication associated with abortion is more common in women carrying a pregnancy to term and giving birth: a "woman's risk of death associated with childbirth was approximately 14 times higher than that associated with abortion."[275] The State's purported interest in women's health was mobilized against women, not for them.

While health exceptions to abortion regulations have generally been seen as provisions that protect women, the ritualization and desexualization present in a wide area of women's reproductive health law suggest that a broader health exception may also lead to further government assertions of a State interest in "health" in non-abortion contexts. Including a mental-health based health exception, for example, would require a definition of "mental health" which could be exported to other, non-abortion law and used to truncate women's rights to make their own decisions later in pregnancy or even in non-reproductive-health contexts. Health protection may come with a price. It may very well be a price worth paying, but that decision should take into account the history of health protection and current law and politics before it is made.

B. Abandoning the State's Purported Interest in Reproductive Health

When it comes to legal regulation related to women's reproductive health, women are in the quintessential double-bind.[276] Most people would agree that

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270. *See, e.g.*, Press Release, Ctr. For Reprod. Rights, House Subcommittee Amends Federal Legislation to Ban Abortion at 20 Weeks Nationwide, (June 4, 2013), *available at* http://reproductiverights.org/en/press-room/house-subcommittee-amends-federal-legislation-to-ban-abortion-at-20-weeks-nationwide ("We urge the members of the House Judiciary Committee to respect the Constitution and defend women's health and rights by rejecting this harmful and misguided bill.").

271. A few fetal pain based laws do include limited exceptions. *See, e.g.*, La. Rev. Stat. Ann. § 40:1299.30.1 (2013) (allowing abortion for "medically futile" pregnancies); Ark. Code Ann. § 20-16-1305 (2013) (listing an exception for rape or incest).

272. McCormack v. Hiedeman, 900 F. Supp. 2d 1128, 1150 (D. Idaho 2013) (refusing to give credence to the argument that the ban was enacted to preserve women's health and citing the title of the legislation in question, the "Pain-Capable Unborn Child Protection Act").

273. ACOG Amicus, *supra* note 265, at 14–16 (noting that abortion is "far safer than the only available alternative—i.e., carrying a pregnancy to term and giving birth").

274. *Id.; McCormack*, 900 F. Supp. 2d at 1150.

275. ACOG Amicus, *supra* note 265, at 14–16.

276. Martha Chamallas, Introduction to Feminist Legal Theory 10–11 (3d ed. 2013); Chamallas, *supra* note 60, at 862 ("The feminists' twin focus on freedom and equality means that no one legal stance—

the real issue is not whether the State should take *any* action to protect women's health. For example, few would argue that more work is not needed to lower maternal mortality. Pregnant women are at an especially high risk in the United States as compared with the rest of the developed world:[277] Amnesty International calls the United States' maternal mortality rate "shocking."[278] Nonetheless, maternal fetal health funding is under attack.[279] The issue is not whether but *how* and *when* the State should act.

Neither wholesale acceptance of State intervention in women's health nor the wholesale rejection of State intervention in women's bodies comes without a cost.[280] Calling on the State to protect women means that laws and jurisprudence will contain language that allows them to do so, and, as this Article shows, language that "protects" women's health can be used by the state to intervene in their ability to make autonomous health decisions. Desexualization and ritualization can both signify and propel this problem. The goal, then, should be to develop health regulations that are designed to maximize health outcomes with a minimal degree of legal interference and avoid the legal manufacturing of mothers through desexualization, ritualization, or both.

One way for the State to improve women's health during their reproductive years is to abandon desexualization and recognize that women are entitled to have sex for pleasure. By abandoning desexualization, the State can improve the availability and use of contraceptives, for example, which is only part of a larger legal regime that protects the ability of women to make real choices about whether and when to have children. Increased availability of contraceptives will both benefit women's health and save the government money by preventing unplanned pregnancies.[281]

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interventionist or noninterventionist—can ever be presumptively correct without careful analysis of the power relationships at play in a particular regulatory context.").

277. Mark Duell, *America Has Worst Maternal Death Rate of Any Industrialized Nation, Claims Shocking Study*, Mail Online (May 5, 2011), http://www.dailymail.co.uk/health/article-1383244/America-worst-maternal-death-rate-industrialised-nation.html.

278. *USA Urged to Confront Shocking Maternal Mortality Rate*, Amnesty Int'l. (Mar. 12, 2010), http://www.amnesty.org/en/news-and-updates/usa-urged-confront-shocking-maternal-mortality-rate-2010-03-12.

279. News Release, Am. Congress of Obstetricians & Gynecologists, Maternal and Child Health Advocates Decry Impact of Proposed Budget Cuts, (May 22, 2013), *available at* http://www.acog.org/About%20ACOG/News%20Room/News%20Releases/2013/Maternal%20and%20Child%20Health%20Advocates%20Decry%20Impact%20of%20Proposed%20Budget%20Cuts.aspx ("The American Academy of Pediatrics (AAP), American Congress of Obstetricians and Gynecologists (ACOG), Association of Maternal & Child Health Programs (AMCHP), March of Dimes and the National WIC Association (NWA) stand in strong unified opposition to the House Appropriations Committee's FY 2014 allocations and urge Congress to invest in maternal and child health programs in the next fiscal year and beyond.").

280. West, *supra* note 41, at 1394; Frances Kissling, Opinion, *Abortion Rights are Under Attack, and Pro-Choice Advocates are Caught in a Time Warp*, Wash. Post. (Feb. 18, 2011), http://www.washingtonpost.com/wp-dyn/content/article/2011/02/18/AR2011021802434.html.

281. Guttmacher Inst., In Brief: Fact Sheet, Facts on Unintended Pregnancy in the United States 3 (2012) http://www.guttmacher.org/pubs/FB-Unintended-Pregnancy-US.html (estimating that in 2006, expenditures

Abandoning ritualization in a continuing pregnancy also holds promise for improving health outcomes because doing so would require abandoning laws that nominally, at best, protect women's health but diminish their reproductive choices. In the context of abortion services, abandoning ritualization would require major changes in the way we view abortion, moving it from a shameful act of maternal avoidance to an act of reproductive health management. Moving away from medical rituals in abortion care and diversifying birth choices in continuing pregnancies may actually improve health outcomes by allowing women to freely make reproductive choices that are most suitable for their situation.[282]

Ridding laws of desexualization and ritualization will require major changes in how we view women and reproduction on political, legal, medical, and societal levels. That will be neither easy nor immediate. Until then, by examining law and policy for the presence of ritualization and desexualization, one can determine (1) what is the true goal of a law passed; (2) the potential that the control over the woman exerted in the law or policy could be exported to or co-opted by other areas of law; and (3) whether that potential is worth the risk given the importance of a health-related goal.

Conclusion

Desire motivates consensual sex. It motivates every action related to pregnancy, be it to have sex, to prevent pregnancy, to bring pregnancy about, or to control its progress and end. There can be no child without a woman. This fact makes women simultaneously the most powerful and the most vulnerable individuals subject to State regulation. We cannot escape the fact that women are essentialized by society and by the law specifically: they are pushed to act like mothers regardless of whether they have children.[283]

Society focuses myopically on abortion as the defining concern in women's health.[284] By looking at abortion, contraception, and birth-related care, we see that desexualization and ritualization underlie State attempts to control women's reproductive autonomy in a variety of contexts and that "health" is increasingly used as a political tool instead of a medical end.

for births resulting from unintended pregnancies nationwide were $11.1 billion). *See generally* Jeffrey T. Jensen and Leon Speroff, *Health Benefits of Oral Contraceptives*, 27 Obstetetrics & Gynecology Clinics N. Am. 705 (2000) (detailing specific health benefits of particular contraceptives).

282. *See, e.g.*, *Home Birth Complications 'Less Common' Than Hospital*, BBC News (June 13, 2012), http://www.bbc.co.uk/news/health-22888411.

283. Reilly, *supra* note 28, at 157–58.

284. Paltrow, *supra* note 16.